Henry Yeates, MD • Tammy Jacobs, MD

(Office Only) MRN: ______________________

PATIENT NAME: ______________________

DOB: ___/___/______ AGE: _____ SEX: M / F

DATE: ____/____/_______

SUBCUTANEOUS IMMUNOTHERAPY (ALLERGY SHOTS) SERUM REFILL FORM

Please fill out completely and fax back for refills.
Please allow 2 weeks for serum refills and delivery.

Bottle: ________ Dilution: ________________ Dose: _________

Bottle: ________ Dilution: ________________ Dose: _________

Bottle: ________ Dilution: ________________ Dose: _________

Provider:

☐ Henry Yeates, MD ☐ Tammy Jacobs, MD

If you obtain your injections at another physician office (otherwise leave blank):

Delivery:

☐ Office Pick-up ☐ Mail Out to ($10 S&H): ____

Accepting Physician Address

Your allergy serum needs to be refilled. In order to refill your serums, we need to have your permission. Please sign and date below. If you have any questions, please call us at (801) 226-3600.

Signature: ____ Date: _____/_____/_________

Phone: (______) _______-___________

________ of Vials $ _____________

Revere Health Allergy & Immunology • Phone (801) 226-3600 • Fax (801) 224-3811

Orem: 159 North 400 West, Suite B-8, Orem, UT 84057