



---

**ALLERGY EXTRACT ORDER FORM**

Mixing Department: 2709 N. Tejon Street  
Colorado Springs, CO 80907  
(719)473-0872 office (719)630-3658 fax

---

The doctor has explained this treatment plan and I have had the opportunity to ask questions. I understand that some insurance companies do not cover antigen and injections, and if that is the case, I will be responsible for payment. I understand the commitment required for allergy immunotherapy.

By signing this form, I authorize Asthma & Allergy Associates, P.C. to make allergy extracts based on the provider's treatment recommendations.

Provider: Daniel F. Soteres, MD MPH   Luke M. Webb, MD   James W. Fulton, MD   Tracy L. Kruzick, MD MPH

Injection Location:    Tejon    Briargate    Pueblo    Canon City    \*\*Other

PATIENT'S LEGAL NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

\*INSURANCE PROVIDER: \_\_\_\_\_

NEW PATIENTS:    TRADITIONAL    CLUSTER    SLIT    FOOD    VENOM

PATIENT, PARENT OR GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

---

*REORDER PATIENTS ONLY: YOU MUST HAVE BEEN SEEN WITHIN THE PREVIOUS 12 MONTHS*

---

**STAFF USE: Please fill out completely.**

REORDERS:    LAST SEEN: \_\_\_\_\_    LAST TESTED: \_\_\_\_\_    APPT SCHEDULED: \_\_\_\_\_

VIAL A:    DATE OF LAST TREATMENT: \_\_\_\_\_    DILUTION: R Y B G S    DOSE: \_\_\_\_\_    FREQ: \_\_\_\_\_

VIAL B:    DATE OF LAST TREATMENT: \_\_\_\_\_    DILUTION: R Y B G S    DOSE: \_\_\_\_\_    FREQ: \_\_\_\_\_

VIAL C:    DATE OF LAST TREATMENT: \_\_\_\_\_    DILUTION: R Y B G S    DOSE: \_\_\_\_\_    FREQ: \_\_\_\_\_

*\*If your insurance requires a prior authorization or referral this must be in place BEFORE mixing.*

*\*\*There is a \$12 shipping and handling fee due BEFORE antigen can be shipped. Please call 719-473-0872 for payment options.*