Southdale pediatric associates, ltd.
Pediatric and Adult Allergy
Kristin Larson, PA-C MeeLee C. Nelson, M.D
3955 Parklawn Avenue * Suite 110 * Edina, MN 55435 * (952) 831-4454 ext. 3
501 E. Nicollet Boulevard * Suite 200 * Burnsville, MN 55337 * (952) 898-5900 ext.3
PLEASE FAX REQUEST TO * 952-278-6948

ALLERGY SERUM REORDER FORM

➔***SERUM CANNOT BE MADE AND BILLED SOONER THAN 6 MONTHS FROM DATE OF LAST SERUM BILLING***←

To re-order your serum: Complete, sign and return this form below to our office by mail or fax.

Serum CANNOT be made unless we receive this signed form or written authorization.

Date Requested: _____

Patient's Name: _____ Date of Birth: _____

Insurance Company: _____ID #:_____ Group #:_____

Vials Needed: 1:1000 1:100 1:10 1:1 (Office use only)

Date of last shot: Serum: Concentration: Dose:

6 month supply_____ 12 month supply_____ (**WILL REQUIRE ALLERGIST APPROVAL**)

Please indicate the office location where you receive allergy shots:

Burnsville_____ Edina_____ outside Clinic_____ (Please complete address below)

Clinic Name: _____ (Outside clinics please fax original shot sheets)

Clinic Address: _____

State: _____ Zip: _____ Clinic Phone Number_____-_____-_____

Name of person making request: _____

Please allow 2 weeks from date requested for this to be processed.
It is my responsibility to verify with my insurance carrier that I have coverage for this service and to obtain any necessary referrals or forms. I understand that I am responsible for any co-pays, co-insurance, deductible, and/or self-pay amounts that may apply.

➔ ***PLEASE NOTE 1:1 (RED) VIALS WILL EXPIRE 1 YEAR FROM WHEN THEY WERE MADE.*** ←

Patient's or Guardian's (if not 18 years of age) Signature: _____

Printed Name: _____