Southdale Allergy & Asthma
3955 Parklawn Avenue, Suite 110, Edina, MN 55435
501 E. Nicollet Boulevard, Suite 200, Burnsville, MN 55337
Phone # 952-278-7010 Fax # 952-278-6948

Mee Lee C. Nelson, M.D **Britta K. Sundquist, M.D.**

ALLERGY SERUM REORDER FORM

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

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:

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: _____

City: _____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 or guardian (if not 18 years of age) signature: _____

Printed name: _____