Southdale pediatric associates, ltd.
Pediatric and Adult Allergy
Dr. Schroeckenstein * Dr. Nelson
3955 Parklawn Avenue * Suite 210 * 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

To re-order your serum:
Complete and sign the form below and return it 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:	Bottle #:	Dose:	

6 month supply_____ 12 month supply_____

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 received in our office for this request 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.
Patient's or Guardian's (if not 18 years of age) Signature: _____

Printed Name: _____