The William Storms Allergy Clinic
And The Cough Center

1625 Medical Center Pt., Ste 190
Colorado Springs, CO 80907

Tel: 719.955.6000
Fax: 719.955.9595

www.stormsallergy.com

William W. Storms, MD

Pediatric & Adult Allergy, Asthma, & Immunology

Kathryn Blair, PhD, FNP-BC **Kelly Eskew, FNP-BC**
Carol Halle,FNP-BC, AE-C **Julia Mesnikoff, FNP-BC** **Kori Schulte, FNP, BC, AE-C**

900 Indiana Ave, Ste C
Pueblo, CO 81004

Tel: 1-866-615-3885
Pollen report: 719.955.1933

www.stormspollen.com

EXTRACT REORDER

Your allergy extracts need to be reordered. Please complete this form (or have the shot facility do it for you) sign and date below to authorize us to prepare new extract for you. By signing, you agree to be responsible for any charges not covered by insurance.

- Extracts are prepared and billed in a three or six month supply, depending on your insurance.
- There is a postage charge for shipping your extract that insurance does not cover. We ask that you pay for this before extract is shipped. We will contact you prior to shipping to make payment arrangement.

If the patient is less than 18 years old, a parent or guardian must sign.

HMO patients: We need a copy of your current referral in order to prepare the antigen.
Please fax a current copy of your insurance card with this form.

If you have any questions please call our office. Please fax or mail this form to our office **two weeks** prior to expiration to allow time to process and mail extracts.

Patient:

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

Current Insurance: ______________________________

IT Location (where you get your shots)

Doctor or Clinic: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

Extract (Trees, grass, etc) ________________ Date of last injection: _____________ Dose: ___________ Dilution: (1/20 etc) __________________

Extract (Trees, grass, etc) ________________ Date of last injection: _____________ Dose: ___________ Dilution: (1/20 etc) __________________

Extract (Trees, grass, etc) ________________ Date of last injection: _____________ Dose: ___________ Dilution: (1/20 etc) __________________

______________________________ ______________________________

Patient's SIGNATURE or Parent/Guardian signature (If patient is under 18) *Date Signed*