COOL SPRINGS ALLERGY (615) 771-8800 Fax: (615) 771-5664

• ALL INFORMATION MUST BE COMPLETED •

EXTRACT REORDER CARD

Order Date: _____

Patient's Name _____ Extract Number _____

Frequency of injections: _____ Date of last injection: _____

CONTENT:	LAST CONCENTRATION & DOSAGE:	CONCENTRATION NOW ORDERING:
#1		
#2		
#3		

PATIENT SIGNATURE: _____

MAIL NEW EXTRACT TO:

Doctor's Name: _____

and Address: _____

_____

Ordered by: _____ Phone#: ( ) _____

PLEASE MAIL/FAX RECORDING SHEETS! • PLEASE ORDER EXTRACT TWO WEEKS IN ADVANCE •