Allergy & Asthma Clinic of East Lansing

NEW START EXTRACT ORDER

Patient Name: _____ **Date of Birth:** _____

Insurance: _____

Clinic: □ **East Lansing** □ **St Johns**

Consent- I authorize, by my signature below, AACEL to bill for allergen extract and its preparation. Each allergy extract is made specifically for you and once made can only be used for your allergies. If you receive your shots in another medical office, you will need to contact our office for each new set of vials. If you discontinue allergy shots prematurely, you will still be financially responsible for those allergy extracts which have already been processed.

Patient Consent: _____ **Date:** _____

FOR OFFICE USE ONLY

Allergy Extract Order

Vial A

Mold 1:10	
Cockroach 1:20	

VIAL B

Mite 10,000au		**Horse** 1:50	
Cattle 1:20		**Grass** 100,000BAU	
Feather 1:10		**Grass/Alfalfa/CP** 100,000BAU	
Cat 10,000bau		**Corn Pollen** 1:20	
Dog 1:10		**Alfalfa** 1:20	
Guinea Pig 1:10		**Weed** 1:20	
Rabbit 1:10		**Ragweed** 1:20	
Mouse 1:20		**Tree** 1:20	

Starting Level

Level 0 Level 1 Other: _____ **Starting Dose** 0.05ml 0.1ml 0.3ml Other: _____

Incremental Dose

0.05 0.1ml Other: _____

Ending Level

Level 3 Level 4 **Ending Dose** 0.3ml 0.5ml Other: _____

Patient Account Number: _____

Ordered in ModuleMD: _____

Written Order: Dr. Kalfa

Serum Prepared By: _____

Billing Units: _____