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T 530.896.2200
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ANTIGEN REFILL REQUEST

Date: ________________

Patient Information

Name: ____ Date of Birth: __________________

Address: ____

Home Phone: ____________________________ Work or Cell Phone: ______________________________

Antigen Number: __________________________ Vial Number & Dilution: ___________________________

Physician Information

Name: ____ Phone: _________________

Address: ____ Fax: ___________________

The following information must accompany this completed form for a request to be processed:

1. **Copy of the most recent <u>Patient Injection Record</u>** showing injection dates, dosages and reactions, if any.
2. **Copy of both sides of the patient's current insurance**.
3. **Signed <u>Immunotherapy Consent Form</u>** (see attached) from the patient or guardian.
4. **Copy of proof of eligibility for the current month for Medi-cal patients**.

Please allow up to six (6) weeks for antigen to be prepared and delivered via Fedex to the physician office listed above.