

WELLNESS RESOURCE MEDICAL CLINIC
PH. 949-249-9449 FAX: 949-249-4951
ANTIGEN ORDER FORM

PATIENT NAME _____ DATE: _____
 ADDRESS: _____ PHONE NUMBER: _____

SINCE EACH ANTIGEN ORDER IS PREPARED INDIVIDUALLY, THE FORM MUST BE SUBMITTED 7 DAYS IN ADVANCE. ALLOW FOR EXTRA TIME IF MAILING YOUR FORM.

1. HOW OFTEN DO YOU TAKE YOUR ANTIGENS? _____
 2. ANY ADVERSE REACTIONS AT INJECTION SITE?

 3. SYRINGE PRESCRIPTION REFILL NEEDED?

 4. LAST CLINIC VISIT _____
 5. LAST SKIN TESTING PERFORMED _____

6. ANY NEW MEDICATIONS? _____

 7. ANY NEW ENVIRONMENTAL TRIGGERS?

 8. SPECIAL REQUESTS OR COMMENTS?

INJECTION RECORD SHEET

DATE	ANTIGEN BOTTLE	AMOUNT	REACTION		DATE	ANTIGEN BOTTLE	AMOUNT	REACTION

IS YOUR INJECTION RECORD COMPLETE? _____
 PICK-UP DATE: _____ OR MAIL DELIVERY (\$10.00) _____
 EXPRESS MAIL DELIVERY (\$25.00) _____

SIGNATURE: _____

REVIEWED: _____
 PATTI BYRON, LABORATORY CQI DIRECTOR
 PATTI@WELLNESSRESOURCEALLERGY.COM

APPROVED: _____
 KEVIN HEGEWALD MD