Allergy Laboratories, Inc.
PO Box 348
Oklahoma City, Oklahoma 73101
Tel: (800) 654-3971 Fax: (800) 811-3389
www.allergylabs.com

TREATMENT SET / REFILL ORDER

Allergy Labs Acct #_____ Date _____

Physician Name

_____

Address _____

_____

Phone _____

Fax _____

Patient Name

_____

DOB _____

Order Placed by _____

Email _____

NEW PATIENT

☐ Prepare a four (4) vial treatment set for this patient from the attached allergy test result, Based on the Fadal/Nalebuff Five Fold Alternative Formulation.

Allergen RAST classes to be included in treatment set _____

ESTABLISHED PATIENT / REFILL

☐ Prepare 10ml maintenance vial: Previous Lot # _____ Strength _____

☐ Prepare 10ml maintenance vial: Previous Lot # _____ Strength _____

If the total number of allergens exceeds 15 allergens, provide the allergens in 2 treatment sets.

Special Instructions _____
_____
_____

Physicians Signature _____ **Date** _____

FAX TO: (800) 811-3389