(Office Only) MRN: _____

Revere Health Allergy & Immunology
Phone (801) 226-3600 ● Fax (801) 224-3811
Orem: 159 North 400 West, Suite B-8, Orem, UT 84057

PATIENT NAME: _____
DOB: ____/____/_____ AGE: _____ SEX: M / F
DATE: ____/____/_____

Payment to be made at the time of order
.
Please allow 2 weeks for serum refills and delivery.

Bottle: _____ Dilution: _____ Dose: _____
Bottle: _____ Dilution: _____ Dose: _____
Bottle: _____ Dilution: _____ Dose: _____

Number of Vials: One Vial/$110 per month Two vials/$220 per month Three vials/$330 per month
Number of Months: _____ (6 vials maximum)

Charge: $ _____

Office Pick-up. If you select office pick-up, but are unable to do so, and need us to mail it out instead, we will require a written statement mailed to us. Please initial_____.

Mail Out to ($25 S&H due prior to shipment):
_____
*There are risks to mailing the serum, as the serum may degrade in temperature extremes, thus rendering the serum less effective.
*Please note that we are also not responsible for lost or damaged serums in the mail.

Signature: _____ Date: _____/_____/_____
Phone: (_____) _____-_____