Allergy and Asthma Associates, P.C.

PATIENT REQUEST FORM

Patient Name: ___________________________________ Date of Birth: ______/______/_________

Who to call if there's any question about the form:________________________ Phone: ____________________

Self-Carry Epinephrine/Inhaler? **YES/NO** Self-Administer Epinephrine/Inhaler? **YES/NO**

Has the patient had any anaphylaxis? **YES/NO** **Weight**: ________lbs

TYPE OF REQUEST: (Choose one per request):

◯ School/Camp/Disability Form (provide form)

◯ Letter From Provider (please explain) ____

ONCE REQUEST IS PROCESSED, PLEASE NOTIFY ME BY:

◯ Email: ____ ◯ Text:_____________________________

ONCE NOTIFIED, I WOULD LIKE MY REQUEST: (choose one)

◯ Emailed to: ____

◯ Faxed to: ____

◯ Left in office for pick up (select one): ◯ STERLING OFFICE ◯ MCLEAN OFFICE

I UNDERSTAND A CARD ON FILE IS REQUIRED AND ANY FEES WILL BE CHARGED AFTER THE REQUEST HAS BEEN FULFILLED. PLEASE CHECK WITH FRONT DESK ABOUT CHARGES.

______________________________________ ________/_______/____________

SIGNATURE **DATE**

****OFFICE USE ONLY****

REQUEST FORM RECEIVED ON: ________/_______/___________ **FORMS COMPLETED BY:** ________________________

CHARGED AMOUNT $___________ **CARD ON FILE UP-TO-DATE** ☐