



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 \$ _____ # OF FORMS TO BILL _____ CARD ON FILE UP-TO-DATE ☐