Please complete this entire form before ordering a new vial. Mail, fax, or bring this report to our office. **Please allow 2 weeks for more vaccine.**
tina@kevinlundemd.com

Kevin Lunde, MD
4701 W. Plano Parkway
Suite 150
Plano, TX 75093
Phone 972-985-3223
Fax 972-964-0562

Home Report After Allergy Injection

Name: _____

Address: _____

City: _____Zip Code_____

Daytime Phone Number: _____

E-mail Address: _____

Please answer the following questions

☐ No local swelling from any injection
☐ Local swelling greater than 50 cent size (Which injection #_____)

☐ No generalized symptoms after any injection
☐ Generalized symptoms within 30 minutes after injection (Which injection #_____)

☐ Allergy symptoms generally improved over time
☐ Allergy symptoms not improved over time

Date of last injection: _____ How often are you taking injections? _____

Date/Arm/Dose:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

☐ Need more allergy vaccine. **Please allow 2 weeks for more vaccine.**

Please be advised that if your insurance changes and requires a referral or authorization to receive allergy injections, you will be responsible for all charges for services received between the effective date of your new insurance and the effective date of your authorization to receive immunotherapy.

Please provide the following if your insurance has changed:
Name of Insurance Co: _____
Phone Number to verify benefits: _____
Insurance Address: _____
Policy Holder's Name: _____
Group # _____ ID # _____ Date of Birth _____

? Mail vaccine to above address or o Vaccine will be picked up at the office
(There is a $4.00 Charge for mailing vaccine)