Goddard Health Center
620 Elm Ave. Norman, OK 73019
Phone (405) 325-8732 **Fax** (405) 325-7542

ALLERGIST CHECKLIST

(to be completed by Allergist's Office upon initiation of treatment and when sending new serum)

Patient Name_____ DOB_____ Today's Date_____

Allergy Facility_____

Allergist_____ Tel #_____ Fax #_____

Copy of empty shot record included: YES____ NO____

Current shot record included: YES____ NO____

Missed dose instructions included: YES____ NO____

Allergy serum reorder form included: YES____ NO____

Instructions on *when* to reorder serum included: YES____ NO____

Number of vials being sent: 1 2 3 4 Other_____

Vial color/strength: silver green blue yellow red Other_____

Frequency of shot administration_____

Suggested next shot: Dose_____ mL/cc Vial color/strength: _____

Suggested next shot dose mentioned above is only valid through (date): _____

Maximum dose that is ever to be given to a patient: Dose_____mL/cc

Does patient have current epi pen: YES____ NO____

Date of next scheduled allergist visit: _____

Name of person completing this form_____

Contact information for questions_____