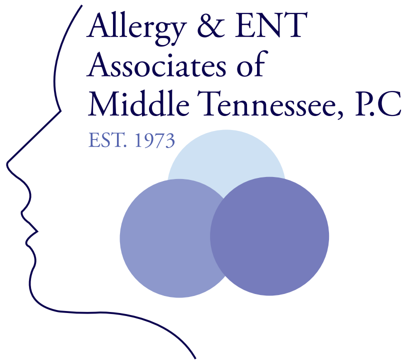

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*Adult and Pediatric Diseases of the Ear, Nose, and Throat * Head & Neck Surgery*
*Allergy Testing and Treatment * Hearing and Balance Disorders*

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Sublingual Drops (SLIT) Reorder Form

Order Date:____

Patient's Name:____

Address:____

Date of Birth:________________Phone Number:____________________

Do you need written instructions:_____________________________

Date of drops last taken:___________________________________

Frequency of drops:_______________________________________

Amount you are taking:_____________________________________

Any reactions to the drops?_________________________________

Do you take blood pressure medication?________________________

If YES, name of medication?__________________________________

PLEASE ALLOW 3-5 DAYS FOR PREPARATION OF MIX

Drops must be paid for PRIOR to mix being made.
EMAIL: appt@myallergyent.com
FAX: (615) 277-0592
MAILED: to address below

Credit Card # ____

Expiration Date:_________CVV (3-digit security code)___________

Amount Paid:_______________if you want them MAILED add $7.00

Summit Outpatient Center
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