**Sublingual Drops (SLIT) Reorder Form**

Order Date:

Patient’s Name:

Address:

Date of Birth: Phone Number:

Do you need written instructions? Y or N

Date of drops last taken:

Frequency of drops:

Amount you are taking:

Any reactions to the drops?

Do you take blood pressure medication? Y or N

If YES, name of medication:

PLEASE ALLOW 3-5 DAYS FOR PREPARATION OF MIX

Drops must be paid for PRIOR to mix being made.

FAX: 903-596-7002

MAILED: to address below

Credit Card #

Expiration Date: CVV (3-digit security code)

Amount Paid: if you want them MAILED add $7.00