AAOA

PRACTICE RESOURCE TOOL KIT

Sample Office Forms

Materials presented in this tool kit are intended as resource only and should not be construed as guidance

WWW.AAOALLERGY.ORG

Sample Patient Form Resource

The following pages include samples of different forms you may consider for your practice. These forms are intended as samples only and are not official AAOA forms. We highly recommend consulting with your practice attorney and state regulations to define the best protocols and forms for use in your practice.

- Patient Information Samples
    - Symptoms of Allergy Reactions
    - Allergy Skin Testing Considerations (2)
    - Consent for Allergy Shot Treatment
    - Immunotherapy Consent (2)
    - Sublingual Immunotherapy: Patient Information & Consent " Testament for Providing Allergy Injections
    - Acknowledgement of Symptoms of Allergy Reaction
    - Acknowledgement of Epi-pen Instruction
    - Influenza Vaccine
    - New Patient Information
    - Allergy Questionnaire (3)
    - Allergy Pre-Testing & Treatment Questionnaire
    - Patient Information: Symptoms of Allergy Reactions
- Office Form Samples
    - Allergy Testing: Intradermal Dilutional Testing " MQT Recording Form
    - Allergy Testing: Vial Mixing Form
    - Allergy Treatment: Shot Log

SAMPLE

Patient Information

Symptoms of Allergy Reactions

You should be aware of possible symptoms after receiving an allergy shot and/or skin testing.

Local Skin reactions:

May occur 20 minutes to 36 hours after a skin test or injection

- Arm redness and swelling
- Enlarged skin whealing (testing wheals greater than a half-dollar)
- Hives

Call our office immediately at (**phone number)** to speak with one of our nurses or medical providers. If you cannot reach us immediately, you may apply ice to your arm and take Benadryl or as instructed (can cause drowsiness).

Systemic Reactions (anaphylaxis, shock):

Onset usually 15-20 minutes after a skin test or injection, but can occur up to 2 hours later

- Difficulty breathing, shortness of breath, wheezing or high pitched breathing sounds
- Feeling of the throat closing
- Persistent coughing
- Tongue and lip swelling
- Hives/generalized itching
- Anxiety, confusion
- Heart palpitations and chest pain
- Skin flushing and warmth
- Nausea and/or vomiting

If these symptoms occur after you leave the office, please go to your nearest Emergency Room or call 911.

You must wait at least 20-30 minutes in the office after receiving an allergy shot to monitor for any signs and symptoms of shock. We are sorry for any inconvenience, but absolutely NO exceptions. A medical provider must check you before you leave. This is for your safety.

If you are receiving allergy shots, you will be given instructions and a prescription for an Epi-pen (adrenalin) to use in these emergency situations. You should also have Benadryl with you and at home in case of a reaction. Please remember that Benadryl can cause drowsiness.

Call our office immediately if you have any questions. Do NOT exercise the day of testing and/or allergy shots since this can increase the risk of these reactions.

SAMPLE

Patient Information - Allergy Skin Testing Considerations

You have been scheduled for allergy skin testing. Please fill prescriptions and bring the epinephrine injection (Epi-pen) with you on the day of testing. If you do not have your epinephrine injection, this will cause delay in testing and you will have to reschedule for another time.

Once testing begins, plan to be in our office for approximately 1.5 hours. If needed, we will provide you with a work/school excuse note.

Attached is a sample list of medications that interfere with skin testing. If you are taking any of these medications, please call the office to speak with one of our healthcare providers or nurses for further instructions.

- You must be off all anti-histamines for one (1) week prior to testing (see list for names).
- **If you are taking a medication in the beta-blocker class, our policy is that we cannot perform skin testing on you because of the complications this medication may cause in the event of an emergency.** NOTE: Never stop one of these medications without first discussing with the physician that prescribed it.
- If you are taking certain anti-depressants/mood stabilizers (see list), these may interfere with skin testing results and therefore we cannot test you unless you provide documentation from the prescribing physician that it is safe to stop. NOTE: Never stop one of these medications without first discussing with the physician that prescribed it.

  - If you are taking medications that interfere with skin testing and still wish to be allergy tested, you will need to provide written permission from the prescribing doctor stating it is safe for you to stop these medications.

Prior to your skin test appointment please let our healthcare providers know:

1. If you are taking any beta blockers or antidepressants. Beta Blockers may worsen allergic reactions and may prevent adrenalin (epinephrine) from reversing anaphylaxis (shock).
2. If you are pregnant.
3. If you have: fever, wheezing, shortness of breath, chest cold, or are using your rescue inhaler more than two times a week. **(Skin testing will be rescheduled if your asthma is not well controlled)**
4. Any medications including over the counter medications you are taking (bring a list if necessary).

All medications for Asthma, including inhalers, should be taken unless otherwise directed by your physician. If you are taking expectorants/decongestants as well as nasal steroids you may continue.

There are no food or beverage restrictions prior to testing; in fact, we encourage you to eat prior to testing. You will be able to drive at the completion of testing. Please remember to wear a short sleeved or sleeveless shirt for testing.

Since this is a popular form of testing, we ask that you please cancel your appointment at least 3 days ahead of time. Please call our office anytime with questions.

SAMPLE

CONSENT FOR ALLERGY SHOT TREATMENT

1. Consent: I ___________________________________ [Patient Name] consent to have my doctor and other health care personnel under his/her supervision to give me Allergy Shot Treatment.

2. Allergy Shot Treatment: I understand that "Allergy Shot Treatment" is also known as subcutaneous immunotherapy. I understand that getting Allergy Shot Treatment means that I will get Allergy Shots. Allergy Shots will be given to me using a small needle to place the allergy medicine under my skin. Allergy Shots will be given every week, and advanced both in strength and in interval between injections per my doctor's instructions.

3. Reason for Allergy Shot Treatment: I have allergies and understand that the reason I am having Allergy Shot Treatment is to help control my allergy symptoms. I understand that Allergy Shot Treatment can be helpful for patients who have significant allergies that are not controlled by allergy medicines. Allergy Shot Treatment is helpful about 80% to 90% of the time when patients follow the treatment plan as advised by their doctor. More often than not, it takes about 6 to 9 months to help improve or control allergy symptoms with allergy injections.

4. Risks, Benefits and Alternatives to having Allergy Shot Treatment: After talking with my doctor, I understand that there are risks, benefits and alternatives to Allergy Shot Treatment, which may include, but are not limited, to:

Risks:

- Reactions where I get the Allergy Shots such as Pain, Itching, Swelling, Redness, Bleeding or Bruising
- Reactions from Allergy Shots because of other medicines that I may be taking such as vitamins and herbs that I forgot to tell my doctor I was taking
- Shock (anaphylaxis), which is a serious reaction, that can lead to death. Signs and symptoms of shock include but are not limited to:

SAMPLE

- Difficulty breathing, shortness of breath, wheezing or high pitched breathing sounds
- Feeling of the throat closing
- Persistent coughing
- Tongue and lip swelling
- Hives/generalized itching
- Anxiety, confusion

- Heart palpitations and chest pain
- Skin flushing and warmth
- Nausea and/or vomiting

Benefits: I understand the benefit of the Allergy Shot Treatment is to help control my allergy symptoms.

Alternatives / Risks of Alternatives: I understand that there are alternatives to having Allergy Shot Treatment and there are risks associated with those alternatives which include, but are not limited to:

- continued or worsening symptoms

I understand that there are alternatives to Allergy Shot Treatment and these include:

- Allergy medicines that I can take by mouth such as oral antihistamines, leukotriene inhibitors, and steroids
- Nasal Sprays
- Allergy drops that I can put under my tongue (sublingual immunotherapy)

5. Anticipated Results and Cautions: The goal of Allergy Shot Therapy is to control my allergy symptoms.

I understand that it is very important to tell my doctor about all of the medicines, vitamins, and herbs that I am taking before I get any allergy shots because they could make me have a bad reaction.

I understand that if I am **taking medicines known as beta-blockers, I should not get Allergy Shots. If I do not know if the medicine I am taking is a beta-blocker, I will ask my doctor. I**

Patient Initial _____

SAMPLE

will also read the list of contraindicated medications to see if I am taking any of these. If I am taking a beta-blocker, or a doctor orders one for me later, I must tell my allergy doctor right away.

I understand that I MUST tell my doctor **BEFORE** I get my allergy shot if I have asthma or feel any asthma-like symptoms such as chest tightness or shortness of breath, chest cold symptoms, or have been diagnosed with pneumonia or bronchitis. Any of these symptoms could cause me to have a serious reaction of shock (anaphylaxis).

Exercising hard after I get my shot, could increase my risk of having a severe allergic reaction. Therefore, I should not exercise on the day I get my shots. After I get my shot, I know that I MUST stay in the doctor's office for at least 20 to 30 minutes. Before I leave the office, I must check my arms for any reaction. If I feel that I may be having any reaction to the shot, I will tell my doctor or the staff right away. I will not leave the office. I will get treatment or medicines needed to help me. I will also get a prescription for an epinephrine pen (medicine to help me if I have a reaction) which I must bring with me to every doctors visit. I will be instructed how to give myself a shot of the epinephrine medicine if I have a reaction and I am not in my doctor's office. I will tell my doctor when I use the medicine.

6. Acknowledgement: I understand that the Allergy Shot Treatment that I will be having has been discussed with me. The discussions have included:

- a full description of the procedure(s);
- its risks;
- its benefits;
- any alternative procedures and/or treatments, including the risks of those alternatives, if any;
- the option of non-treatment including its risks; and
- the anticipated results of the procedure(s) or treatment(s).

7. Consent: I have read this consent or have had it read to me, and fully understand what it says. In addition, I have been given a chance to ask whatever questions I had regarding the procedure(s) to be performed and my questions have been answered to my satisfaction.

I knowingly, willingly and voluntarily consent to the procedure outlined above.

Patient Initial _____

SAMPLE

Patient /Guardian Signature: ______________________________ Date: ___/___/___

Witness Signature: ______________________________________ Date: ___/___/___

*   *   *

Physician Declaration:

I have discussed the procedure as detailed above including the possible risks, benefits, complications, alternative treatments and associated risks, (including non-treatment) and anticipated results. I have answered all of the patient's questions (or questions by the guardian or the patient's authorized representative) that were asked. The patient (or guardian or authorized representative) indicated that he/she has been adequately informed and agrees to the procedure.

Physician Signature: ____________________________________ Date: ___/___/___

Patient Initial _____

SAMPLE

IMMUNOTHERAPY CONSENT

I understand the possible adverse reactions to immunotherapy that include, but are not limited to:

- Localized reactions such as soreness, redness, itching and swelling at the injection site.
- Mild systemic reactions such as nasal congestion, itchy watery or red eyes, and sneezing.
- Rare complications such as: wheezing, coughing, or shortness of breath, respiratory failure, generalized hives, swelling of tissue around the eyes, tongue, or throat, and abnormalities of the heart beat with loss of ability to maintain blood pressure and pulse.

I have read the patient information sheet on immunotherapy and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of immunotherapy and these questions have been answered to my satisfaction.

I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions. I also agree that if I have an adverse allergic reaction to the injections that the physician-in-charge has permission to treat the reaction.

I verify that I am not taking Beta-blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician and consent to continued use of my injections with knowledge of the risks associated with that.

I will wait in the allergy department for 20-30 minutes following each injection. I have an epi pen that I have been trained how to use. I can also use that if I start to have an allergic reaction after I leave the office after either allergy testing or allergy injection. As parent or legal guardian, I understand that I must accompany my child throughout the entire time period after an injection.

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I acknowledge the fact with my signature that I am authorizing the office to bill for allergen vaccines, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the vaccine has been made. Vaccines may be prepared up to 1-2 weeks prior to my appointment. I agree to obtain prior authorization, if needed, from my insurance plan.

SAMPLE

I have read this consent or have had it read to me, and fully understand what it says. In addition, I have been given a chance to ask whatever questions I had regarding the procedure(s) to be performed and my questions have been answered to my satisfaction.

I knowingly, willingly and voluntarily consent to the procedure outlined above.

Patient /Guardian Signature: ______________________________ Date: ___/___/____

Witness Signature: ______________________________________ Date: ___/___/____

SAMPLE

* * *

Physician Declaration:

I have discussed the procedure as detailed above including the possible risks, benefits, complications, alternative treatments and associated risks, (including non-treatment) and anticipated results. I have answered all of the patient's questions (or questions by the guardian or the patient's authorized representative) that were asked. The patient (or guardian or authorized representative) indicated that he/she has been adequately informed and agrees to the procedure.

Physician Signature: ____________________________________ Date: ___/___/____

Immunotherapy Consent Form

It is the policy of **(practice name)** to provide safe and effective immunotherapy to all eligible patients who desire it. Allergy immunotherapy, (allergy shots) contain water extracts of pollens, mold, mites, insects or animal dander to which a patient has been shown to be allergic by skin testing. These mixtures are tailor- made for each patient. Allergy immunotherapy works by gradually building antibodies and changing the allergy response that your body has to your allergies. Avoidance of allergens when possible is the first and foremost the most important form of therapy. Secondly, oral and topical allergy medications are an option to reduce symptoms although they will only inhibit reactivity for short periods of time and not alter the immune system to make one less allergic over time as allergy shots or immunotherapy will do.

In the course of immunotherapy, very small doses of allergen are given to the patient, and are gradually increased each week to change the immune system making you less reactive. This gradual build-up of the allergen decreases the possibility of the injection itself causing an allergic reaction. The injections are given weekly until a "maintenance dose" of allergen is reached. It may take up to a year for symptom relief to occur, but you can often begin to see change in 6 – 12 weeks. Allergy injections are a commitment of approximately 3-5 years.

For safety reasons there are many reasons why you may NOT receive a shot. They include: increased temperature; exacerbation of asthma; upper respiratory symptoms consistent with a cold, especially coughing or wheezing; hives; poison ivy, or other rashes; severe sunburn or bee sting. Any immunization, including the flu shot, and allergy injection should be given at least one week apart. Beta-blockers which are used to treat high blood pressure, glaucoma and occasionally migraine headaches, increase the risks associated with immunotherapy since appropriate medical therapy to resolve an allergic reaction to immunotherapy will not be effective to reverse that reaction and can lead to severe potentially life threatening reactions. Any change in your medications or the addition of a beta blocker must be reported immediately, and immunotherapy may need to be stopped at that time

As with any substance injected into the body, there may be an adverse reactions. Local reactions include swelling, redness and itching at the injection site. You may use an ice pack on the area, take over the counter antihistamines (such as Benadryl, which may cause drowsiness, or zyrtec, allegra, claritin), or prescription antihistamines. Mild systemic reactions include sneezing, itchy, watery or red eyes, nasal congestion and/or "runny nose" with itching of ears, nose, or throat. Rarely, severe reactions occur, which are generalized anaphylactic reactions that are potentially life threatening. Symptoms may include but are not limited to wheezing, coughing, or shortness of breath, generalized hives, swelling of tissue around the eyes, the tongue, or throat, respiratory distress or difficulty breathing, drop in blood pressure with cardiovascular compromise, and even death. We monitor all patients receiving shots for 20 minutes after their injection to monitor for such reactions since they usually happen within that time frame. Some reactions do occur after leaving the office, and must be reported PRIOR to receiving your next injection.

SAMPLE

All patients receiving allergy injections must be evaluated by one of our physicians every 3 months during your escalation phase and then yearly while on maintenance to ensure accurate and appropriate treatment.

Patients under the age of 18 must have a parent or legal guardian present for the administration and waiting period after an allergy injection.

I certify that I give permission for **(practice name)** to administer allergy immunotherapy to me as outlines above with the associated risks.

(add more specific information consistent with OR consent form for geographic area)

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signature of patient date

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signature of legal guardian if patient under 18 date

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witness

SAMPLE

Physician Declaration:

I have discussed the procedure as detailed above including the possible risks, benefits, complications, alternative treatments and associated risks, (including non-treatment) and anticipated results. I have answered all of the patient's questions (or questions by the guardian or the patient's authorized representative) that were asked. The patient (or guardian or authorized representative) indicated that he/she has been adequately informed and agrees to the procedure.

Physician Signature: ______________________ Date: ___/___/___

Patient Information and Consent - Sublingual Immunotherapy (Allergy drops)

1. Consent: I ______________________________ [Patient Name] consent to have my doctor and other health care personnel under his/her supervision to give me Allergy Sublingual (under the tongue) Immunotherapy drops.

2. Sublingual (under the tongue) Immunotherapy (Allergy Drops) Treatment: Sublingual (under the tongue) immunotherapy (SLIT), also known as allergy drops, has been used in Europe for approximately 40 years. Allergy drops can work well and be safer than allergy shots. Allergy drops are not approved for use in the United States, but many allergists are using SLIT as a treatment option for their patients. The allergens used in allergy drops are the same as the prescribed allergens used in allergy shots. The allergy drops are made in the same way as allergy shots. The difference is the way that you get the allergy medicine. The drops use a dropper bottle that puts drops under the tongue. Allergy shots are injected into the arm.

You will take a few drops of the allergy drops and put it under your tongue and hold it there for 2 minutes before swallowing.

3. Reason for Allergy Drops: The reason(s) allergy drops are being offered as an option is that they can be an alternative to allergy shots for:

- People who are fearful of shots
- People who do not want to take shots
- People who feel they can not follow the allergy doctor's plan for shots that require repeat visits to the doctor's office
- I have allergies and understand the reasons

4. Risks, Benefits and Alternatives to having Sublingual Allergy Drop Immunotherapy: After talking with my doctor, I understand that there are risks, benefits and alternatives to sublingual allergy drop immunotherapy, which may include, but are not limited to the following:

Risks:

- Itching and swelling of the mouth
- Abdominal pain

Patient Initial _____

SAMPLE

- Nasal rhinitis (inside of the nose swells and a runny nose)
- Conjunctivitis (the eyelids swell and the whites of the eyes are red)
- Hives.

Benefits: I know that a benefit to this treatment is that I may need less medicine to help control my allergy symptoms after I start taking the allergy drops. I know that I will not need as many visits to the allergy clinic each year, which may help me to not lose time from work or school. I know that it may be easier for me to keep up with my allergy therapy because I can take the allergy drops at home. The drops do not cause pain. The drops have a sweet taste.

Alternatives / Risks of Alternatives: I understand that there are alternatives to having Allergy Drop Treatment and there are risks associated with those alternatives which include, but are not limited to:

- Continued or worsening symptoms

I understand that there are alternatives to Allergy Drop Treatment and these include:

- Avoid allergens
- Medical management of symptoms with other allergy medications and nasal sprays
- Allergy subcutaneous (shot) therapy

5. Anticipated Results and Cautions: The doctor will prescribe a schedule. Patients take their drops each day for 3-5 years, the same time period as shots. You can take your drops everywhere with you, as long as you refrigerate them as often as possible. Drops not refrigerated may lose their strength.

I know that allergy drops may not improve my allergy symptoms, and that if they do not work I may need to talk with my doctor about allergy shots. The FDA has not approved the use of allergy drops, so they will not be covered by my insurance and I will have to pay for the drops.

6. Acknowledgement: I understand that the Allergy Sublingual (under the tongue) Immunotherapy Drops that I will be having has been discussed with me. The discussions have included:

- a full description of the procedure(s);
- its risks;
- its benefits;

Patient Initial _____

SAMPLE

- any alternative procedures and/or treatments, including the risks of those alternatives, if any;
- the option of non-treatment including its risks; and
- the anticipated results of the procedure(s) or treatment(s).

7. Consent: I have read this consent or have had it read to me, and fully understand what it says. In addition, I have been given a chance to ask whatever questions I had regarding the procedure(s) to be performed and my questions have been answered to my satisfaction.

I knowingly, willingly and voluntarily consent to the procedure outlined above.

Patient /Guardian Signature: ______________________________ Date: ___/___/___

Witness Signature: ______________________________________ Date: ___/___/___

* * *

Physician Declaration:

I have discussed the procedure as detailed above including the possible risks, benefits, complications, alternative treatments and associated risks, (including non-treatment) and anticipated results. I have answered all of the patient's questions (or questions by the guardian or the patient's authorized representative) that were asked. The patient (or guardian or authorized representative) indicated that he/she has been adequately informed and agrees to the procedure.

Physician Signature: ____________________________________ Date: ___/___/___

Patient Initial _____

SAMPLE

CONSENT FOR ALLERGY TESTING

1. **Consent**: I ________________________________ [Patient Name] consent to have my doctor and other health care personnel under his/her supervision to give me Allergy Testing.

2. **Allergy Testing**: I understand "Allergy Testing" is a set of allergens applied to my forearms using a device that pricks the skin and applies a drop of allergen to the site. The prick sites are measured after 20 minutes and then, an additional injection of selected allergens may be applied at a strength that is determined by your prick results. Each injection site is measured after 10 minutes. This test will take approximately 60-90 minutes. The test carries only mild discomfort and is very well tolerated.

3. **Reason for Allergy Testing:** I have allergy symptoms and understand that the reason I am having Allergy Testing is for diagnosis and additional treatment. I understand that Allergy Testing is can potentially identify specific environmental allergens that may be causing me to suffer from allergies. All allergens used in testing contain extracts of pollens, molds, mites, insects or animal dander to which I may possibly be allergic. The allergens can be applied by various testing methods which will be determined by my doctor.

4. **Risks, Benefits and Alternatives to having Allergy Testing:** After talking with my doctor, I understand that there are risks, benefits and alternatives to Allergy Testing, which may include, but are not limited to:

Risks:

- Reactions such as Pain, Itching, Swelling, Redness, Bleeding or Bruising at the site of testing.
- Local or systemic reactions from Allergy Testing because of other medicines that I may be taking such as vitamins and herbs that I forgot to tell my doctor I was taking
- Shock (anaphylaxis), which is a serious reaction, which can lead to death. Signs and symptoms of shock are:
  - Difficulty breathing, shortness of breath, wheezing or high pitched breathing sounds

SAMPLE

- Feeling of the throat closing
- Persistent coughing
- Tongue and lip swelling
- Hives/generalized itching
- Anxiety, confusion
- Heart palpitations and chest pain
- Skin flushing and warmth
- Nausea and/or vomiting

Benefits: I understand the benefit of the Allergy Testing is to help control my allergy symptoms.

Alternatives / Risks of Alternatives: I understand that there are alternatives to having skin Allergy Testing by doing in vitro testing or testing my blood to identify allergy reactivity or even just taking allergy mediation to reduce allergy symptoms.

In Vitro testing or blood testing is less sensitive and may miss some of my potential allergy reactivity. It is also more expensive and testing may be limited by insurance.

There are risks associated with just taking medications to control allergy symptoms that include, but are not limited to:

- Continued or worsening symptoms
- Side effects from medication.

I understand that there are alternatives to Allergy Testing and these include:

- Allergy medicines that I can take by mouth such as oral antihistamines, leukotriene inhibitors and steroids
- Nasal Sprays
- Allergy drops that I can put under my tongue (sublingual immunotherapy)

Patient Initial _____

SAMPLE

5. Anticipated Results and Cautions: The goal of Allergy Testing is to learn about my allergies.

I understand that it is very important to tell my doctor about all of the medicines, vitamins, and herbs that I am taking before I get allergy shots or testing because they could make me have a bad reaction.

I understand that if I am taking a **beta-blocker, I have an increased risk with testing and am not a good candidate. I will ask my doctor if I do not know if I am taking is a beta-blocker. I will tell my doctor if I am taking a beta-blocker, or if a doctor orders one for me later, and I am to start immunotherapy.**

I understand that I MUST tell my doctor **BEFORE** I get my allergy test if I have asthma or feel any asthma-like symptoms, chest cold symptoms, such as chest tightness or shortness of breath. Any of these symptoms could cause me to have a serious reaction or even shock (anaphylaxis).

Exercising hard after I get my allergy testing could increase my risk of having a severe allergic reaction. Therefore, I should not exercise on the day I get my test. Before I leave the office, I must check my arms for any reaction. If I feel that I may be having any serious reaction to the shot, I will tell my doctor right away. I will not leave the office. I will get treatment or medicines needed to help me. I will also get a prescription for an epinephrine pen (medicine to help me if I have a reaction) which I must bring with me on the day of testing or I will not be able to be tested that day. I will be instructed how to give myself a shot of the epinephrine medicine, and tell my doctor when I use the medicine in the event that I have a reaction and I am not in my doctor's office.

6. Acknowledgement: I acknowledge that the Allergy Testing that I will be having has been discussed with me. The discussions have included:

- a full description of the procedure(s);
- its risks;
- its benefits;
- any alternative procedures and/or treatments, including the risks of those alternatives, if any;
- the option of non-treatment including its risks; and
- the anticipated results of the procedure(s) or treatment(s).

Patient Initial _____

SAMPLE

7. Consent: I have read this consent or have had it read to me, and fully understand what it says. In addition, I have been given a chance to ask whatever questions I had regarding the procedure(s) to be performed and my questions have been answered to my satisfaction.

I knowingly, willingly and voluntarily consent to the procedure outlined above.

Patient /Guardian Signature: _____________________________ Date: ___/___/___

Witness Signature: _____________________________________ Date: ___/___/___

* * *

Physician Declaration:

I have discussed the procedure as detailed above including the possible risks, benefits, complications, alternative treatments and associated risks, (including non-treatment) and anticipated results. I have answered all of the patient's questions (or questions by the guardian or the patient's authorized representative) that were asked. The patient (or guardian or authorized representative) indicated that he/she has been adequately informed and agrees to the procedure.

Physician Signature: ___________________________________ Date: ___/___/___

Patient Initial _____

SAMPLE

Testament for Providing Allergy Injections

Our patient _________________________ is receiving or has requested to receive allergy immunotherapy at your office or medical facility. Please certify with your signature that the following is available at your facility:

- Personnel trained and familiar with subcutaneous injection technique.
- Personnel trained in the treatment of anaphylaxis.
- Proper equipment and medications for the treatment of anaphylaxis.

Name of Medical Practice or Facility ____

Signature: ____________________________________ Date: ________________

SAMPLE

Staff Use:

Name: ______________________________

MRN: ____________ DOB: ___________

Acknowledgement of Symptoms of Allergy Reaction

Patient Information Sheet

I, ____________________________(print name), have received a Symptoms of Allergy Reactions Patient Information Sheet from my doctor prior to my Allergy Testing.

I have been given a chance to ask whatever questions I had regarding the **Symptoms of Allergy Reactions Patient Information Sheet** and my questions have been answered to my satisfaction.

Patient /Guardian Signature: ___________________________ Date: ___/___/

SAMPLE

Staff Use:

Name: ______________________________

MRN: _____________ DOB: ___________

Acknowledgement of Epi-pen Instruction

I, ____________________________(print name), have received a prescription from my doctor for an Epi-pen prior to my Allergy Testing to have available after testing and also during immunotherapy. I brought my Epi-pen with me today as instructed. Before my Allergy Testing, I was shown how to use the Epi-pen correctly.

I have been given a chance to ask whatever questions I had regarding the right way to use the Epi-pen and my questions have been answered to my satisfaction.

Patient /Guardian Signature: ___________________________ Date: ___/___/___

SAMPLE

INFLUENZA VACCINE

I, _______________________ give permission to "NAME OF YOUR GROUP" to administer the the following vaccine to me.

____ Trivalent (type A & B) influenza vaccine

____ Quadravalent influenza vaccine

I understand that this vaccine does protect against the novel H1N1 strain commonly known as "swine flu".

Possible adverse reactions to the influenza vaccine have been described as:

- Soreness at the vaccination site for up to two days.
- Fever, malaise, myalgia and other systemic symptoms can occur 6-12 hours after vaccination and persist one or two days.
- Immediate; presumably allergic reactions, such as hives, angioedema or various respiratory problems probably result from hypersensitivity.
- Guillain-Barre syndrome (GBS) which is characterized by ascending paralysis which is usually self-limited and reversible was associated with the 1976 swine influenza vaccine. Studies from 1977-1991 indicated slight increased risk of GBS after influenza vaccine.
- Other neurological disorders, including encephalopathy have been reported.

I am aware of the possible risks listed above and consent to receive the vaccine.

- I am NOT allergic to chicken egg, thimerosal, gelatin or formaldehyde
- I do NOT have a fever, active infection or illness at this time
- I am NOT pregnant

Signature: ______________________________________Date: ________________________

SAMPLE

Flulaval Lot Number: ______________ Expiration Date: _______

Given in: Right / Left deltoid Date/Time administered: _______________ Year: _______________

SIGNATURE OF PERSON ADMINISTERING VACCINE____

NEW PATIENT INFORMATION

Attach Patient Label Here

Department of Otolaryngology

Visit Date:____________________

Patient name: ____ Age:_______ Date of Birth: __________

Parent/Guardian (if pt is a minor):____

Address: ____

Home Phone (_____)______________________________ Alternate Phone (_____) ___________________________

Referring Physician

Name:______________________________

Address:____________________________

____

____

Phone: (_____)__________________

Family Physician

Name:______________________________

Address:____________________________

____

____

Phone: (_____)__________________

What health concerns prompted today's visit?

____

____

____

____

____

____

Please list any **PAST** or **CURRENT** medical problems:

____

____

____

____

____

Please list any **SURGERIES** you have had:

____

____

____

SAMPLE

Please list any **MEDICATION** you are taking:
____
____
____

Medication Allergies: NO____________ YES______________; list below

Medication Name:	Reaction Experienced:

Please Continue On the Back

Social History:
Occupation:____

Have you EVER or do you CURRENTLY use any of the following:
- Never used any of the following.
- **Tobacco**: What form?_________________ Have you stopped? When?_________
  How much per day are/were you using?_________________________________
- **Alcohol**: What type?_____________________ How often:_________________
- **Other drugs**: What type?____________________ How often________________
  Have you stopped ?___________________ When?________________________

Family History:

Please list any medical problems or diseases that are common in your family:
____
____
____

Do you have any problems with your : (please explain any yes answers)
- Blood pressure No____ Yes_______________________________
- Heart/lungs No____ Yes_______________________________
- Stomach/Bowels No____ Yes_______________________________
- Kidney/Urinary tract No____ Yes_______________________________
- Muscles/Joints No____ Yes_______________________________
- Skin No____ Yes_______________________________
- Eye/vision No____ Yes_______________________________
- Diabetes/thyroid No____ Yes_______________________________
- Allergic/Immune system No____ Yes_______________________________
- Infections No____ Yes_______________________________
- Neurological/
  Psychological problems No____ Yes_______________________________
- Weight loss/ fevers No____ Yes_______________________________

SAMPLE

Please circle the number that best represents the level of pain or discomfort you are having today RELATED to your ears, nose, throat, head, or neck. 0 = pain free ; 10 = severe pain.

0	1	2	3	4	5	6	7	8	9	10

Location of pain?:____

Vital Signs: BP_____ / _____; HR _____; Resp _____; Temp _____; Wt ______; Ht ______

Physician Notes:____

SAMPLE

Allergy Questionnaire

Name: ______________________________ DOB: __________ Date: ________

This questionnaire is designed to help determine if some of your symptoms are related to disturbed body functions. Please read each question carefully. Then circle Yes or No to indicate your answer.

Are there any foods that you crave or eat frequently?	Yes	No
Are there any foods that you dislike?	Yes	No
Are you awakened between the hours of 1:00 and 5:00 am with the following symptoms: headaches, dizziness, stomach cramps, bloating, or dry cough?	Yes	No
Have any family members had hay fever, asthma, hives, chronic skin condition, migraine headaches, colitis?	Yes	No
Did you have any of the following during childhood:	Yes	No
eczema, hay fever, asthma or food feeding problems.		
Do you ever have itching of the skin, palate or roof of mouth?	Yes	No
Do you frequently notice swelling of the ankles, feet, hands or face on arising in the morning?	Yes	No
Do you have obvious fatigue two to three hours after a meal?	Yes	No
Do you eat snacks frequently between meals?	Yes	No
Do you have excessive chilling when a sudden change in temperature occurs?	Yes	No

SAMPLE

Do you have frequent migraine headaches or pain in the back of the head?	Yes	No
Do you experience belching, abdominal distention, bloating or cramps following meals?	Yes	No
Have you noticed numbness of the face, arms or legs at periodic intervals for no apparent cause?	Yes	No
Do you have drowsiness, headache or bloating following the ingestion of a cocktail, glass of beer or wine?	Yes	No
Are you allergic to Penicillin?	Yes	No

SAMPLE

Name: ____(Please Print)   DOB: ______________

Allergy Questionnaire - PLEASE CHECK ALL THAT APPLY

1. **Do you have a history of?**

Asthma [ ] Yes [ ] No **How often do you use your rescue inhaler?** __________

Ever been hospitalized for severe attack? __________

Beta-Blockers [ ] Yes [ ] No **Which medications do you take?** ______________

MAO-inhibitors [ ] Yes [ ] No **Which medications do you take?** ______________

Repeated sinus infections? [ ] Yes [ ] No

Repeated ear infections? [ ] Yes [ ] No

Severe Allergic Reaction or Anaphylaxis (shock)? [ ] Yes [ ] No

2. **Ever been hospitalized for allergic reaction?** [ ] Yes [ ] No

3. **Ever been allergy tested?** [ ] Yes [ ] No

4. **General Symptoms**

Pollen Allergy Symptoms	**Dust Allergy Symptoms**	**Mold Allergy Symptoms**
Check line beside symptom	*Are your symptoms:*	*Are your symptoms:*
____Worse outdoors	____Worse indoors	_____Worse outdoors from 4 to 9 pm

SAMPLE

____Worse on windy days ____ Better outdoors

____Worse on cool evenings

____Worse on clear days ____Worse 30 min. after retiring ____Worse in low, damp places

____Worse outdoors 7 to 11 am ____ Worse in cold weather ____Worse mowing / playing in grass

____Worse in change of temp ____ Worse when sleeping ____Worse on windy days

____Worse in warm or cool air ____ Worse when dusting

____Better indoors

____Better outdoors

5. **Are your symptoms: ALL THE TIME OR SOMETIMES** (circle one)

6. **What medicines have helped your allergy symptoms?**________________________________

7. **During what months do you usually have allergy symptoms?**____________________________

8. **During what months are your allergy symptoms most severe?** ____________________________

Check all that Apply

Does your nose feel?

	Never	Sometimes	Seasonally	Constantly
Stuffy				
Runny				
Itchy				
Post-Nasal Drip				

Do your eyes?

	Never	Sometimes	Seasonally	Constantly
Full/Plugged up				
Itchy				
Sore/Painful				

SAMPLE

Wet/Have discharge				

Do you sneeze frequently?

	Never	Sometimes	Seasonally	Constantly
Year Round				
Seasonally				
Daytime				
Nighttime				

Do you cough frequently?

	Never	Sometimes	Seasonally	Constantly
Year round				
Seasonally				
Daytime				
Nighttime				

SAMPLE

10. **How many colds do you usually have per year?** ________________________________
11. **Do you smoke?** [ ] Yes [ ] No **How much?** _________ **How long?** __________
12. **Are you around other people that smoke?** [ ] Yes [ ] No **How often?** _________
13. **Do you have any dogs (inside or outside)?** ________ **Cats (inside or outside)?** _________
14. **Do you have birds?** ____________ **Do you have houseplants?** ___________________
15. **Do you have feather pillows?** _____________ **Do you have a down comforter?** _________
16. **What type of housing do you have?**

Single House_____ Duplex ______ Apartment _____ Condo _____ Other: _______ (specify)

17. **When was it built?** __________

18. Where is it located? **City _____ Suburban_____ Rural _____ Farm _____**

19. Do you have any food allergies? [ ] Yes [ ] No **Specify: ______________________**

20. Is there a family history of allergies? [ ] Yes [ ] No **If yes, specify who: _______________**

___________________________ ___________________________ ____________

Patient Signature **Physician Signature** **Date**

SAMPLE

Inhalant Allergy Questionnaire

Do I have Inhalant Allergies?

Question		
Do you have postnasal drip?	Yes	No
Do you have nasal congestion?	Yes	No
Do you have recurrent sinus infections	Yes	No
Do you have asthma or wheezing	Yes	No
Are your symptoms worse indoors?	Yes	No
Are your symptoms worse outdoors?	Yes	No
Do your symptoms increase with the return of cold weather	Yes	No
Do you have irritation or itching of the eyes?	Yes	No
Are your symptoms worse while dusting or sweeping?	Yes	No
Are your symptoms worse on humid evenings?	Yes	No
Are your symptoms seasonal?	Yes	No
Are your symptoms worse in basements?	Yes	No
Are your symptoms worse in barns?	Yes	No
Are your symptoms worse in certain homes?	Yes	No

SAMPLE

Do you react to animals? Yes No

SAMPLE

Allergy Pre-Testing and Treatment Questionnaire

Name: ___________________________________ DOB: __________ MRN: ___________

This questionnaire is to improve patient safety for your allergy testing and/or allergen immunotherapy injection (allergy shots). Please review and answer the following questions. The nursing staff will review your responses and notify your physician if they have any questions or concerns about whether you should receive your testing or injection(s) today. **If you are pregnant or have been diagnosed with a new medical condition, please notify the staff.** (Please check the appropriate answer.)

1. Have you had increased asthma symptoms (chest tightness, increased cough, wheezing or shortness of breath) in the past week? [ ] **yes** [ ] **no**
2. Have you had increased allergy symptoms (itching eyes or nose, sneezing, runny nose, post-nasal drip or throat clearing) in the past week? [ ] **yes** [ ] **no**
3. Have you had a cold, respiratory tract infection or flu-like symptoms in the past two weeks? [ ] **yes** [ ] **no**
4. Did you have any problems such as increased allergy or asthma symptoms, hives or generalized itching within 12 hours of receiving your last injection, or swelling that persisted into the next day? [ ] **yes** [ ] **no**
5. Are you on any new medications? Please list ______________________________________

____

6. Are you on any eye drops? Please list ____
7. I brought my Epi-pen (adrenaline) with me today [ ] **yes** [ ] **no**

Patient signature: ___________________________________ Date: _______________

To be completed by office staff:

Staff intervention/office visit: ____

____

____

SAMPLE

Patient Information

Symptoms of Allergy Reactions

You should be aware of possible symptoms after receiving an allergy shot and/or skin testing.

Local Skin reactions:

May occur 20 minutes to 36 hours after a skin test or injection

- Arm redness and swelling
- Enlarged skin whealing (testing wheals greater than a half-dollar)
- Hives

Call our office immediately at (**phone number)** to speak with one of our nurses or medical providers. If you cannot reach us immediately, you may apply ice to your arm and take Benadryl or as instructed (can cause drowsiness).

Systemic Reactions (anaphylaxis, shock):

Onset usually 15-20 minutes after a skin test or injection, but can occur up to 2 hours later

- Difficulty breathing, shortness of breath, wheezing or high pitched breathing sounds
- Feeling of the throat closing
- Persistent coughing
- Tongue and lip swelling
- Hives/generalized itching
- Anxiety, confusion
- Heart palpitations and chest pain
- Skin flushing and warmth
- Nausea and/or vomiting

If these symptoms occur after you leave the office, please go to your nearest Emergency Room or call 911.

You must wait at least 20-30 minutes in the office after receiving an allergy shot to monitor for any signs and symptoms of shock. We are sorry for any inconvenience, but absolutely NO exceptions. A medical provider must check you before you leave. This is for your safety.

If you are receiving allergy shots, you will be given instructions and a prescription for an Epi-pen (adrenalin) to use in these emergency situations. You should also have Benadryl with you and at home in case of a reaction. Please remember that Benadryl can cause drowsiness.

Call our office immediately if you have any questions. Do NOT exercise the day of testing and/or allergy shots since this can increase the risk of these reactions.

SAMPLE

ALLERGY TESTING
INTRADERMAL DILUTIONAL TESTING
Tested By:

NAME: ______________________
DATE: ______________________
MD:

Class:	6	5	4	3	2	1	EP
Controls							
Diluent							
Histamine							
Glycerine #2							
Antigens							
Timothy Grass							
Perennial Rye							
Orchard Grass							
Meadow Fescue							
Kentucky Blue Grass							
Johnson Grass							
Bermuda Grass							
Lamb's Quarter							
Mugwort							
Pigweed							
English Plantain							
Giant Ragweed							
Short Ragweed							
Goldenrod							
White Ash							
Birch							
Elm							
Maple							
Oak							
White Pine							
Sycamore							
Black Walnut							
Corn Pollen							
House Dust							
Dust Mite Farniae							
Dust Mite PT							
Cat Dander (Std)							
Dog Dander							
Alternaria							
Aspergillus							
Penicillium							
Cladosporium							
Helminthosporium							
Rhizopus							
Mucor							
Cephaolosporium							
Fusarium							
Pullularia							
Cockroach							

(PRACTICE NAME)
ALLERGY TREATMENT FORM

PATIENT NAME:

PHONE NUMBER:

DATE STARTED SHOTS:

PCP: **Phone:** **DOCTOR:**

Vial contents:									
DATE	Nurse Initials	**Vial 1**		**Vial 2**		**Vial 3**		**Vial 4**	
		Dose	Reaction	Dose	Reaction	Dose	Reaction	Dose	Reaction

Nurse #1 ____________

Nurse #2 ____________

INJECTION FREQUENCY:

ALLERGY TESTING
VIAL MIXING FORM

NAME: ____________________

DATE STARTED SHOTS: ____________________

DOCTOR:

ANTIGEN	EP	Date / Init.	VIAL 1 — # Dil Used						Volume	Total Ag	Pres. Vol, 50% Gly	Diluent Vol, PNS	Total Volume
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20													
21													

Notes:

MQT Recording Form

Patient Name		Age		Sex		DOB	/ /
MRN		Ordered by		Tested by		Date	/ /

Site	Battery A Antigen	Wheal	ID dil# Tested	ID Wheal	End point	Include tx Y / N
1	Histamine (positive control)					
2	Glycerin Control					
3						
4						
5						
6						
7						
8						
Site	**Battery B Antigen**	**Wheal**	**ID dil# Tested**	**ID Wheal**	**End point**	**Include tx Y / N**
1						
2						
3						
4						
5						
6						
7						
8						
Site	**Battery C Antigen**	**Wheal**	**ID dil# Tested**	**ID Wheal**	**End point**	**Include tx Y / N**
1						
2						
3						
4						
5						
6						
7						
8						

Legend for wheal sizes:

Result <3 mm► Put on **#2 ID** ***If:*** ≤6mm = Negative Test ***or*** ≥7mm = E.P. #3.

Result 3-8 mm► Put on **#5 ID** ***If:*** ≤5 mm = E.P. #4 ***or*** 7-8 mm = E.P. #5 ***or*** ≥9 mm = E.P. #6.

Result ≥ 9 mm► **No Additional testing** = E.P. #6

MQT Recording Form

Patient Name | **Age** | **Sex** | **DOB** / /

MRN | **Ordered by** | **Tested by** | **Date** / /

Site	Battery D Antigen	Wheal	ID dil# Tested	ID Wheal	End point	Include tx Y / N
1						
2						
3						
4						
5						
6						
7						
8						
Site	**Battery E Antigen**	**MTII Wheal**	**ID dil# Tested**	**ID Wheal**	**End point**	**Include tx Y / N**
1						
2						
3						
4						
5						
6						
7						
8						
Site	**Battery F Antigen**	**MTII Wheal**	**ID dil# Tested**	**ID Wheal**	**End point**	**Include tx Y / N**
1						
2						
3						
4						
5						
6						
7						
8						

Legend for wheal sizes:

Result <3 mm► Put on **#2 ID** ***If:*** ≤6mm = Negative Test ***or*** ≥7mm = E.P. #3.

Result 3-8 mm► Put on **#5 ID** ***If:*** ≤5 mm = E.P. #4 ***or*** 7-8 mm = E.P. #5 ***or*** ≥9 mm = E.P. #6.

Result ≥ 9 mm► **No Additional testing** = E.P. #6

Prescription for Allergy Immunotherapy

Patient Name ________________________________

Medical Record # ________________________________

Date ________________________________

Physician ________________________________

Mix vials with multiple antigens at five fold dilutions from concentrate. Number indicated is the number of five fold dilutions from concentrate. (Concentrate 1:20, Dilution #1 1:100, Dilution #2: 1:500, Dilution #3 1:2500….) 0.02mL each antigen at 25X prescribed concentration (2 5-fold dilutions more concentrated) for initial vial(s).

Dust / Dander / Cockroach

Cat e1	
Dog e2	
Dermatophagoides p d1	
Dermatophagoides f d2	
Cockroach i6	

Trees

Cedar (t6 Mountain Juniper, Uunipems sabinoides)	
Box elder t1 (Acer negundo)	
Common silver birch t3 (Betula verrucosa)	
Oak t7 (Querus albus)	
Elm t8 (Ulmus Americana)	
Walnut / Hickory t10 (Uuglans californica)	
Sycamore t11 (P. acerifolia)	
Cottonwood t14 (Populus deletoides)	
Pecan, Hickory t2 (Carya pecan)	
White Pine (Pinus strobus)	
White Ash t15 (Fraxinus americana)	
Mullberry t70 (Morns alba)	
Sweet Gum t211 (Linquidambar styracijlua)	

Grasses

Timothy Grass g6 (Phleum pratense)	
Johnson g10 (Sorghum halepense)	
Bermuda g2 (Cynodon dactylon)	

Weeds

Ragweed w1 (Ambrosia elatior)	
Goldenrod w12(Soldidago virgauraea)	
Marshelder w16 (Iva cilianta)	
English plantain w9 (P. lanceolata)	
Lambsquater w10 (Chenopodium album)	
Pigweed w14 (A. retrojlexus)	
Sheep sorrel w18 (Rumex acetosella)	
Nettle w20 (Urtica diocia)	

Molds

Pecillium notatum m1	
Cladsporium herbarum m2	
Aspergillus fumigatus m3	
Candidae albicans m5	
Alernaria alternate m6	
Helmithosporium halodes m8	
Fusarium moniliforme m9	
Rhizopus nigricans m11	
Epicocuccum purpurascens m14	
Curvalaria lunata m16	
Aspergillus niger m207	

Other

MD Signature ___________________________________ Date ________________
Printed Name ___________________________________

Allergy IT Summary Sheet

Patient Name ______________________________

Medical Record # ______________________________

Date ______________________________

Physician ______________________________

Indication(s) for Immunotherapy:
□ Symptoms not controlled with pharmacologic therapy
□ Dependent on allergy medications for multiple years
□ Symptoms severe during one season: ______________________________
□ Quality of life impaired by allergy symptoms
□ Sensitized antigens unavoidable
□ Reasonable trial at antigen reduction/avoidances unsuccessful
□ Allergies believed to be a substantial co-morbidity in other uncontrolled disease: ____
□ Other: ____
____

Physician Initial ______________ Date ___________________

Checklist (physician or nurse initial next to each and date)

	Date	Initial
□ Epi-pen Rx	_____________	____________
□ Consent	_____________	____________
□ Beta blocker information	_____________	____________
□ Compliance Contract	_____________	____________
□ Allergy Test in Chart	_____________	____________
□ Symptoms Scores	_____________	____________
□ Immunotherapy Prescription	_____________	____________

Test Type □ Quant In-Vitro IGE □ Quant Intradermal
Test Date ____
Date to Start □ ASAP or □ ______________________
Escalation □ Standard (5 fold vials, weekly, 0.05 cc increases)
□ Other: ________________________________

(PRACTICE NAME)
ALLERGY TREATMENT FORM

PATIENT NAME:

PHONE NUMBER:

DATE STARTED SHOTS:

PCP: **Phone:** **DOCTOR:**

Vial contents:									
DATE	Nurse Initials	**Vial 1**		**Vial 2**		**Vial 3**		**Vial 4**	
		Dose	Reaction	Dose	Reaction	Dose	Reaction	Dose	Reaction

Nurse #1 ____________

Nurse #2 ____________

INJECTION FREQUENCY:

PRACTICE NAME

Patient Name:_________________________ **MRN:**_________________ **DOB:**________________

Vial# ________ **Exp. Date**_________ **Physician**____________________

Dosage Schedule (One Vial)

WEEK#	SUG. VOL.	VOL. GIVEN	DATE	INITALS	RESULTS/NOTES
1	0.01 ml VIAL TEST				
2	.05 ml				
3	.10 ml				
4	0.15 ml				
5	0.20 ml				
6	0.25 ml				
7	0.30 ml				
8	0.35 ml				
9	0.40 ml				
10	0.45 ml				
11	0.50 ml				
12	0.50 ml				
13	0.50 ml				
14	0.50 ml				
15	0.50 ml				
16	0.50 ml				
17	0.50 ml				
18	0.50 ml				
19	0.50 ml				
20	0.50 ml				

Immunotherapy Record

NAME: ____________________

CONTENTS: ____________________

SUGGESTED SITE: ____________________ **EPI PEN EXPIRATION DATE:** ____________

VIAL TEST: DATE: ____________________ TIME: ____________ WHEAL: ____________

VIAL INSTRUCTIONS: ____________________

LAST INJECTION: DATE: ________________ DOSAGE: __________REACTION: __________

DATE/TIME	MED Δ	D.R.	DOSAGE	INITIAL	TIME INTERVAL	TIME OBSERVED	NOTE

NOTES:____________________

____

Documentation for "out of office" injections

for providers giving the allergy injection

1. Name, address, phone and fax number of the treating physician
2. Paper flow sheet to document
   - **a.** Patient identification
   - **b.** Date
   - **c.** Any new medications since last visit especially beta blocker
   - **d.** Problems with previous injections if any
   - **d.** Overall status of allergy related signs or symptoms
   - **f.** Today's status of allergy related signs—especially asthma
   - **g.** Antigen injection schedule to include for each vial
     - i. Antigen
     - ii. Dilution
     - iii. Dosage
     - iv. Injection site
   - **h.** Problems within 20 minutes of current injection
3. Any routine or special instructions for provider giving the injections
4. Instructions for missed doses, local or system reactions
5. A copy of the last clinic visit note with the allergists

Allergy Treatment Options

What is the best way to treat your allergies? We offer a number of options to explore- from managing symptoms to treating the root cause through immunotherapy. We can help you explore the benefits of each so you can choose which option is best for you.

- **Lifestyle adjustments –** Dietary adjustments and environmental control measures to reduce exposure to indoor and outdoor allergens are critical to reducing your symptoms. Based on your allergic profile, we can offer guidance to help you address those items that affect you most.

- **Medication –** Various medications can improve or relieve allergy symptoms. This includes over-the-counter or prescription medications and nasal sprays. Side effects are possible and can be discussed with your doctor. Medications may be needed lifelong or as long as symptoms persist, but many patients report decreased medication use after immunotherapy begins.

- **Immunotherapy –** Immunotherapy is the only way to change underlying allergic disease by desensitization, which builds your immune system's tolerance to allergens over time. Your treatment is custom-formulated based on the results of your allergy tests. This treatment can be administered in two forms.

    - **Subcutaneous Immunotherapy (SCIT):** For patients age six and over, a series of injections are typically given for a 3-5 year period. Consistency is critical. Patients are asked to wait 20 minutes after receiving injections before leaving the office. Most insurance companies cover injections and the medication vial, though co-pays may apply.

    - **Sublingual Immunotherapy (SLIT):** Allergy drops work much like allergy shots, slowly desensitizing you to what causes your allergies, but they're delivered under your tongue in a liquid form that you can safely take at home. As with allergy shots, most patients taking allergy drops find their treatment takes 3-5 years to complete. Most patients will only need a few office visits each year to assess progress. Because of their safety profile, allergy drops can be an option for all patients including young children. *Most insurance companies will pay for the testing and office visits, but **not** for the drops.*

Patient Information

Symptoms of Allergy Reactions

You should be aware of possible symptoms after receiving an allergy shot and/or skin testing.

Local Skin reactions:

May occur 20 minutes to 36 hours after a skin test or injection

- Arm redness and swelling
- Enlarged skin whealing (testing wheals greater than a half-dollar)
- Hives

Call our office immediately at (**phone number)** to speak with one of our nurses or medical providers. If you cannot reach us immediately, you may apply ice to your arm and take Benadryl or as instructed (can cause drowsiness).

Systemic Reactions (anaphylaxis, shock):

Onset usually 15-20 minutes after a skin test or injection, but can occur up to 2 hours later

- Difficulty breathing, shortness of breath, wheezing or high pitched breathing sounds
- Feeling of the throat closing
- Persistent coughing
- Tongue and lip swelling
- Hives/generalized itching
- Anxiety, confusion
- Heart palpitations and chest pain
- Skin flushing and warmth
- Nausea and/or vomiting

If these symptoms occur after you leave the office, please go to your nearest Emergency Room or call 911.

You must wait at least 20-30 minutes in the office after receiving an allergy shot to monitor for any signs and symptoms of shock. We are sorry for any inconvenience, but absolutely NO exceptions. A medical provider must check you before you leave. This is for your safety.

If you are receiving allergy shots, you will be given instructions and a prescription for an Epi-pen (adrenalin) to use in these emergency situations. You should also have Benadryl with you and at home in case of a reaction. Please remember that Benadryl can cause drowsiness.

Call our office immediately if you have any questions. Do NOT exercise the day of testing and/or allergy shots since this can increase the risk of these reactions.

PATIENT INFORMATION -
MEDICATION GUIDELINES BEFORE ALLERGY SKIN TESTING

Please review the list of medications below for any you are currently taking. Some medicines are contraindicated in allergy skin testing and you must alert our staff if you are taking one of them. This list is a guide only and not meant to be complete. If you have any questions, please call 215-503-8306 to speak with our staff.

IMPORTANT: Never stop any blood pressure/heart (beta-blocker) or antidepressant (tricyclic) medications without first discussing with the prescribing physician. You must provide written permission from that physician stating it is safe to stop.

Medications you must **AVOID for 1 week prior to skin testing **

Beta-Blockers - Oral

Acebutolol/Sectral
Atenolol/Tenormin
Atenolol-HCTZ/Tenoretic
Betaxolol/Kerlone
Bisoprolol/Zebeta
Bisoprolol-HCTZ/Ziac
Carteolol/Cartrol
Esmolol/Brevibloc
Betaxolol/Kerlone
Labetolol/Trandate/Normodyne
Metoprolol/Toprol/Lopressor
Nadol-bendroflunetazide/Corzide
Nadolol/Corgard
Pindolol/Visken
Carvedilol/Coreg
Propanolol/Inderal/Innopran
Propanolol-HCTZ/Inderide
Sotalol/Betapace
Timolol/Blocadren/Cosopt/Betim
Timolol-HCTZ/Timolide
Penbutolol/Levatol

Beta-Blockers - Eye Drops

Betaxolol/Betopic
Carteolol/Ocupress
Levobunolol/Betagan
Levobunolol/AK Beta
Metipranolol/Optipranolol
Timolol/Timoptic

Antidepressants - Tricyclics

Amitriptyline/Elavil
Amoxapine/Ascendin
Clomipramine/Anafranil
Desipramine/Norpramin
Doxepin/Sinequan
Imipramine/Tofranil
Nortriptyline/Pamelor
Protriptyline/ Vivactil
Trimipramine/Surmontil

Antidepressants - Other

Maprotiline/Ludiomil/Deprilept/Psymion
Mirtazapine/Remeron

Anti-Histamines

Allegra	Extendryl	Tavist
Atarax	Hycomine	Trinalin
Atrohist	Kronofed	Tussionex
Benadryl	Nolamine	Tylenol allergy
Bromfed	Nolahist	Tylenol cold
Claritin	Periactin	Tylenol flu
Codimal DH	Phenergan	Tylenol PM
Dimetane Cough	Rynatan	Vistaril
Dura-Vent	Rynatuss	Zyrtec
Semprex	Sinulin	Xyzal
Astelin nasal spray	Antivert	
Astemizole	Fexofenadine	Diphenhydramine
Azatadine	Hydroxyzine	Cyproheptadine
Azelastine	Loratidine	Chlorpheniramine
Brompheniramine	Meclizine	Cetirizine
Methscopolamine	Phenidamine	Promethazine

Medications **ACCEPTABLE for skin testing **

Leukotriene Inhibitors

Montelukast/Singulair
Zafirlukast/Accolate

Beta-2 agonists - Inhaled

Albuterol/Proventil/Ventolin
Metaproterenol/Alupent
Pirbuterol/Maxair
Terbutaline/Brethine

Others

Cromolyn/Intal IH/Nasalcrom

Corticosteroids - oral, inhaled, nasal

Prednisone
Methylprednisolone/Medrol
Dexamethasone
Cortisone
Hydrocortisone
Prednisolone

Steroid nasal sprays
- Beclomethasone/Beconase AQ
- Budesonide/Rhinocort Aqua
- Ciclesonide/Omnaris
- Fluticasone/Flonase/Veramyst
- Mometasone/Nasonex
- Triamcinolone/Nasacort AQ

PLEASE INFORM US IF YOU HAVE BEEN PRESCRIBED A MEDICINE CALLED A BETA BLOCKER

(USED TO TREAT HIGH BLOOD PRESSURE, GLAUCOMA, AND OCCASIONALLY MIGRAINE HEADACHES)

THE FOLLOWING IS A LIST OF SOME OF THE BETA BLOCKERS

Brand Names	Generic Names (typically end in "ol"
Kerlone	betaxolol
InnoPran XL	propranolol
Corgard	nadolol
Metoprolol Succinate ER	metoprolol
Tenormin	atenolol
Toprol-XL	metoprolol
Bystoloc	nebivolol
Inderal	propranolol
Lopressor	metoprolol
Inderal LA	propranolol
Coreg	carvedilol
Coreg CR	carvedilol
Normodyne	labetalol
Sotalol Hydrochloride AF	sotalol
Betapace	sotalol
Betapace AF	sotalol
Blocadren	timolol
Brevibloc	esmolol
Cartrol	carteolol
Levatol	penbutolol
Sectral	acebutolol
Sorine	sotalol
Trandate	labetalol
Visken	pindolol
Zebeta	bisoprolol

Allergen Immunotherapy Systemic Reaction/Anaphylaxis Treatment Record

Name:____ Date:_____________

Date of Birth:_________________ Prescribing Physician:______________________________

Allergens: Tree-Grass-Weed-Mites-Cockroach-Animal Dander-Mold-Hymenoptera

Prior systemic rxn:_________ Hx of asthma?____________

Date/time of injection:________________ Date/time of rxn:___________________

Dilution (Vial #): _______________ New? Yes No

History of the systemic reaction (SR):

Immediate measures:
__Assess airway, breathing, circulation, and orientation
__Epinephrine IM into arm or when possible anterolateral thigh
__Activate EMS (call 911 or local rescue squad) Y/N Time called:_____AM/PM
__Management algorithm reviewed (as needed)

Signs and Symptoms

Respiratory:	**Skin:**	**Eye/Nasal:**	**Vascular:**	**Other:**
Shortness of Breath	Hives	Runny Nose	Hypotension	Difficulty Swallowing
Wheezing	Angioedema	Red Eyes	Chest Discomfort	Abdominal pain, nausea, diarrhea
Cough	Generalized Itch	Congestion	Dizziness	Diaphoresis
Stridor	Flushing	Sneezing		Headache
				Uterine cramps
				Impending doom

Time	Resp. rate/ PEFR	Pulse/ O2 Saturation	BP	Intervention, Medications, Exam Comments

Time of discharge from the office:___________ Condition upon release: ____
Patient instructions:
____
Follow-up call to patient:
Time____
Comments:
____
____
____
WAO Subcutaneous Immunotherapy Systemic Reaction Grading System Final Report:
Grade a-d,or z _______________First symptom _______________ Time of onset of first symptom _______________
Dosage adjustment? ____

Signatures________________________ RN_________________________ARNP/PA _________________________ MD/DO

Medications

Epinephrine – Adult dose:
Children dose:

• Epinephrine1:1000,0.3-0.5mLIM • Diphenhydramine25-50mgIV/IM • Ranitidine 50 mg IV/IM • Methylprednisolone125mgIV/IM • Hydrocortisone250-500mgIV/IM • Dexamethasone10mgIV/IM
• AlbuterolneborMDI:doseasforasthma

Diphenhydramine,1to2mg/kgor25to50 mg per dose (parenterally)

Ranitidine-adults 50mg IV in adults
Peds 12.5 to 50 mg (1 mg/kg)
can dilute in 5% dextrose to a total volume of 20 mL and injected intravenously over 5 minutes.

Cimetidine-(4mg/kg)canbeadministered intravenously to adults, but no pediatric dosage in anaphylaxis has been established

Atropine 0.5 mg IV, repeat every 10 minutes
Glucagon 1-5 mg IV
Ipratropium neb or MDI: dose as for COPD

Glucagon infusion:
1 to 5 mg administered intravenously over 5 minutes and followed by an infusion (5 to 15 µg/min) titrated to clinical response
– In children, 20-30 µg/kg (maximum dose, 1 mg)

glucocorticosteroids
IV q6 hours 1.0 to 2.0 mg/kg/d of methylprednisolone
Oral prednisone, 0.5 mg/kg for less critical episodes

List of Supplies for Anaphylaxis

___ BP cuff/monitor ___ Stethoscope ___ Pulse Ox

Airway and Oxygen

___ Facemask
___ Nasal Cannula
___ Oropharyngeal airways
___ Oral ETT's
___ Intubation laryngoscope
___ Trach set
___ Oxygen tank
___ Ambubag

IV Supplies

___ IV fluids (Normal saline and 5% Dextrose)
___ Catheter needles (gauge 16, 18, 20, 22)
___ Connection tubing
___ Syringes with needles (1 mL, 10 mL, 20 mL)
___ Tourniquet
___ 1" tape
___ Latex-free gloves
___ Alcohol swabs (box)
___ IV Pole

Medications

___ Epinephrine 1:1000
___ Diphenhydramine (Benadryl) 25-50 mg/mL
___ Ranitidine (Zantac) 25-50 mg/mL
___ Methylprednisolone (Solumedrol) 125 mg vial
___ Albuterol MDI/nebulizer
___ Ipratropium MDI/nebulizer
___ Atropine 0.5 mg/mL IV
___ Glucagon 1 mg/mL vial
___ Heparin 10,000 units/mL

REPLACE SUPPLIES WITHIN ONE MONTH OF EXP. DATE. CHECK SUPPLIES MONTHLY AND RE-STOCK AFTER USE.

NOTE: NOT ALL ITEMS NEED TO BE PRESENT IN EACH TREATMENT SETTING.

Initials ______

Date ________

Yeast Allergy Symptoms

Yeast allergy symptoms may include headache, sneezing, itchy nose, itchy eyes, nasal congestion, and sore throat. Yeast (Candida Albicans) is a mold that can be found on surfaces and in food. Some of the more common foods that contain the fungi are cheese, mushrooms, dried fruit, soy sauce, breads, peanuts, tomato sauce, some pasta, and vinegar. The best way to treat an allergy is to avoid the substances that are causing the symptoms or reaction. A yeast free diet should not include any foods containing the above listed items. However, this list is not all inclusive so the person who is allergic would benefit from doing research and reading labels before buying a product. Processed food labels should be read very carefully. Even some vitamin and mineral supplements contain yeast. Some drinks to avoid include beer, wine, tea, coffee, and soft drinks.

Candida albicans is a micro-organism of the fungus family. Candida is found in humans and animals but is usually balanced out in the body by another organism called lactobacillus acidophilus. When candida becomes overpopulated then a person may experience yeast allergy symptoms. Some of the early signs that this is happening may include digestive problems, bloating, constipation, diarrhea, irritability, fatigue, skin rash, white coated tongue or thrush, and dizziness. There is no definitive test to diagnose candida overgrowth but physicians will normally diagnose it based upon the severity and number of symptoms present at the time of an examination.

An imbalance of candida can happen to anyone who takes antibiotics or steroids. Other people who are susceptible are women who take birth control pills, anyone who has diabetes, and anyone who has undergone chemotherapy or been exposed to radiation to treat cancer. People who have indulged in a diet high in sweets, fruit juice, sodas, and refined carbohydrates are susceptible to candida overgrowth and would benefit from going on a yeast free diet. A candida free diet means avoiding any foods that contain yeast as well as sugar, and some carbohydrates. There are suggestions and recommendations on foods to avoid on the Internet as well as ones that are alright to consume.

In most cases candida overgrowth will usually manifest in the digestive system first. An intense overgrowth can cause a condition called leaky gut syndrome. The irritation of the yeast can cause leakage through the intestinal wall of undigested food into the bloodstream. Common symptoms may be similar to yeast allergy symptoms and include abdominal pain, bloating, indigestion, and heartburn. In addition, shortness of breath and asthma may occur. Chronic joint and muscle pain are not uncommon as well as skin rashes, and other types of infections. Before seeing a doctor the person with problems should write down information that could help to diagnose the condition.

Treatments for a yeast infection usually include the use of antifungal drugs and creams. Creams can be used for skin rashes and vaginal infections caused from an overgrowth. In addition, a yeast free diet will keep the problem from occurring again unless the patient is being treated for an infection with antibiotics or has other immune system problems. Taking acidophilus at the same time of taking antibiotics may help to prevent the imbalance that occurs in the digestive tract. Some yogurts found in the supermarket contain active cultures of lactobacillus acidophilus and can be eaten to help to prevent overgrowth of candida albicans. Drug stores and supermarkets usually carry acidophilus as well as many health food stores.

Primarily an infection from candida may be linked to immune system dysfunction. Yeast allergy symptoms are caused by toxins from the overgrowth. Immune system dysfunction can lead to other types of illnesses and allergies. People who suffer with reoccurring sinus inflammation and infection, chronic coughing, sore throats, insomnia, and nervousness should ask their doctor about candida overgrowth. Skin conditions associated with candida allergy include athlete's foot, diaper rash, impetigo, jock itch, dandruff, and dermatitis. Anyone who has had an unexplained rash that will not go away should check with their physician for the possibility of a fungi infection.

Patients who suspect an allergy should avoid sugars, fruit, simple carbohydrates, and foods that seem to make them feel worse. Eating too much sugar will feed the candida and make it multiply. Milk and milk products that contain a high content of lactose should be avoided. Some of the vegetables to limit on a yeast free diet include potatoes, corn, yams, and parsnips. Any foods, sauces, or drinks that contain sugar, syrup, soy, tomato sauce, tomato paste, and other sweeteners or syrups should also be avoided. Pickles or pickled vegetables should be avoided since they are stored in vinegar. A patient who makes healthy lifestyle changes that include eating healthy and exercising may find that most of their symptoms diminish and in time may even completely go away.

Yeast, Malt, Mold Foods & Mold Containing Foods

1. **Yeast Additives**:
The following foods contain yeast as an additive ingredient in preparation (often called leavening or baker's yeast):

Breads:
Light bread, hamburger buns, hot-dog buns, rolls (homemade or canned), canned icebox biscuits (Borden, Pillsbury
and General Mills).
Pastries:
Cookies, crackers, pretzels, cakes and cake mix etc.
Flour:
Enriched with vitamins from yeast – General Mills flour and enrichment wafers, Pfizer Laboratories enrichment products.
Milk:
Fortified with vitamins from yeast.
Meat:
Fried in cracker crumbs and flour, except those listed in No. 7 below.

2. **Yeast Forming:**
The following substances contain yeast or yeast-like substances because of their nature or the nature of
their manufacture or preparation (including brewers and distiller's yeast and malt.)

Vinegars (apple, pear, grape and distilled):
These may be used in such or are used in these foods: catsup, mayonnaise, French dressing, salad dressing, barbeque sauce, tomato sauce, sauerkraut, horseradish, pickles, olives, condiments and spices (pepper, cinnamon),
mince pie, Gerber's oatmeal, and barley cereal.
Fermented beverages:
Whiskey, wine, brandy, gin, rum, vodka, beer, root beer.
Fruit juices:
Citrus fruit (and others), either canned or frozen. Only home squeezed are yeast free!

3. **Yeast Derivatives:**
The following contain substances that are derived from yeast or yeast-like substances:

Vitamins:
Vitamin B capsules or tablets if made from yeast, multiple vitamins, capsules or tablets with Vitamin B made from yeast (Zylax, Zymelos, Zymenol); Lilly's vitamin products that contain Vitamin B12; U.S. Vitamin products (Laxo-Funk, Phoscaron-D, Vi-litron drops); Squibb vitamin products if so indicated on the label; Mead Johnson's vitamins that contain Vitamin B12; Parke-Davis vitamin products (Vibrex); Merck, Sharp & Dohme's vitamin products that contain B12; Lederle's vitamin products; Enco's vitamin products (Mainbee tablets, S.C.T); Massengill vitamins.
Flour:
Those that contain enrichment wafers of Commercial Solvents Corporation or that contain vitamin derived from yeast.
Dormisan Rest Capsules.

4. **Malt Products:**
   Cereals, candy and milk drinks that have been malted and some fermented beverages; also some bakery products.

5. **Mold Foods:**
   Mushrooms, truffles, morsels**.**

6. **Mold Containing Foods:**
   Cheeses:
   All kinds including cottage cheese, buttermilk, cream cheese, sour cream and sour cream butter.
   Foods which acquire mold growths during the preparation of processing or after exposure to air, even when refrigerated:
   Ham, bacon, butter, preserves, jams, jellies, syrups, molasses, canned fruit and vegetables and breads.

7. **Mold Derivatives:**
   Antibiotics or oral drugs which contain antibiotics, meats prepared from animals fed antibiotics, or milk that contains penicillin or other antibiotics.

8. **Instructions:**
   Pancakes, waffles, muffins, cornbread, biscuits, etc., made with baking powder or soda may be substituted for baker's yeast products. Freshly squeezed lemon juice may be used in place of vinegar in mayonnaise.

Please call our office for more information.

SAMPLE