

# FAMILY ALLERGY CENTER, P.C.

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## INFORMED CONSENT FOR IMMUNOTHERAPY

### Section A:

Allergy immunotherapy (shots) contain extracts of pollens (grasses, weeds, trees, molds) or other environmental inhalants to which a patient has been shown to be allergic by skin testing. Venom allergy shots, as the name implies, are actual doses of natural stinging insect venom or its purified components. With either type of injection, as with other substances injected into the body, there may be a shot reaction. These are generally mild and include:

#### Group I:

1. Burning or itching at the injection site
2. Swelling or hives (wheal) at the injection site
3. Redness at the injection site

Occasionally, more severe reactions include:

#### Group II:

1. Generalized hives (welts) or generalized itching
2. Nasal congestion and/or "runny nose" with itching of ears, nose or throat and/or sneezing
3. Itchy, watery or red eyes
4. Swelling of tissue around the eyes, the tongue, or throat
5. Stomach or uterine (menstrual-type) cramps, nausea
6. Wheezing, cough and shortness of breath or chest tightness

Rare complications include:

#### Group III:

1. Abnormalities of the heartbeat
2. Loss of ability to maintain blood pressure and pulse

Severe reactions involving the heart, lungs, and blood vessels, could, if unrecognized and untreated, be FATAL. Experience has shown that the overwhelming majority of reactions which require emergency treatment occur within 15-20 minutes of an injection. It is for this reason that **all patients who receive injections must remain in our waiting room for 20 minutes and then be checked by one of our nurses before leaving our office**. Anyone leaving prior to this time does so against medical advice and repeat offenders may be prevented from receiving his/her allergy shots. This same policy applies to those receiving their allergy injections at another medical facility or clinic. If the symptoms in groups II or III occur, notify the nurse immediately. Do not wait 20 minutes. If these occur after leaving the office, go to the nearest physician attended medical facility for treatment, or call 911. Notify our office during business hours of the episode and what treatment was administered. If receiving injections

at another medical facility and a major reaction occurs, make sure that our office is notified prior to receiving any more allergy injections.

A consensus opinion of Allergists recognize the rare but possible hazards of immunotherapy, and it has been generally agreed that no allergy shots shall be given except under the direct supervision of a CPR-trained physician who has medical supplies at hand to treat a reaction should it occur. This means that home treatments by a nurse, family member or other health professional will NOT be permitted.

**Section B:**

In signing this statement, I acknowledge that I have read fully the information that it contains, and that I have had any questions answered by a nurse or physician. This signed statement will become a part of my chart.

I have read all of the information in Section A of this form, and I certify that I will not attempt to administer my extract, nor will I permit anyone who is not a licensed physician, or under the direct supervision of a licensed physician, to administer these extracts.

I have been informed that I will receive an EpiPen prescription and instructed in its use at my first shot appointment. This will always be carried with me on shot day in case of emergency.

**Section C:**

I understand that the allergy immunotherapy (shots) prescription is unique to my individual case as determined by my clinical history and skin testing results. I recognize that it requires both extract material and professional time to write and compound this prescription. Therefore, I realize my consent to undergo treatment constitutes an obligation to pay for the extract prescription whether or not treatment is undertaken. I understand that some insurance companies limit the volume of extract that I can receive per year and that additional serum used beyond the contract limit will be a non-covered service, therefore payment is my responsibility.

I have discussed my insurance and payment information with the business staff at Family Allergy Center regarding the charges for allergy extract and injections. I authorize Family Allergy Center to order and prepare my allergy extract and understand my account will be charged and insurance filed for these vials.

I further understand that the final responsibility for the payment of these charges is mine. I understand that the allergy extract is being prepared specifically for me and that if I decide not to start or not to continue that my insurance may not cover allergy extract prepared for me which I decide not to use. I also understand that unexpected reactions or interruptions in my injection schedule may result in the expiration of certain vials, causing them to be remade and those additional charges then added to my account.

With this knowledge I request the vials be ordered and prepared for me and I consent to any necessary treatment required in the event of an injection reaction.

Patient's Name \_\_\_\_\_

Signature (parent, if patient is a minor)

Date \_\_\_\_\_

Witness \_\_\_\_\_

Office where injections are to be given \_\_\_\_\_