FAMILY ALLERGY CENTER
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INFORMED CONSENT FOR ALLERGEN IMMUNOTHERAPY INFORMATION

Section A:

Allergy immunotherapy (shots) contain extracts of pollens (grass, weed, tree, mold) or other environmental inhalants to which a patient has been show 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/warmth at the injection site

Occasionally, more severe reactions include:

Group II:

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

Rare complications can include:

1. Abnormalities of the heartbeat
2. Loss of ability to maintain blood pressure and pulse
3. Dizziness or syncope

Severe reactions involving the heart, lungs and blood vessels, could be FATAL (*most often if unrecognized and untreated*). 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 staff before leaving the 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 group II or III occur, 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 on hand to treat a reaction should it occur. This means that in-home treatments by a nurse, family member or other health professional will **NOT** be permitted.

Section B:

In signing this agreement, I acknowledge that I have fully read 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 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 (shot) 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 contract limits **will be a non-covered service, therefore payment is my responsibility** _____**(initial here)**.

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 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 with my treatment 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 _____**(initial here)**. Adherence to the shot schedule is very important for this reason.

I am providing my contact information on the attached forms so that I may be contacted by email, text or phone to notify me of changes in the office shot schedule or contact me if I am off schedule for my injections.

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

Patients Name:_____ Patients DOB: _____

Signature (parent if patient is a minor) _____ Date: _____

Witness: _____

Office where injections are to be given: _____