



Consent for Allergy Testing

1. Consent: I _____ [Patient Name/DOB] 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 45-60 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
 - 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 medication 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)

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 if 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).

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: ___ / ___ / ___