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INFORMED CONSENT FOR ALLERGY IMMUNOTHERAPY

Allergy immunotherapy (shots) contain water extracts of pollens, mold or dust components to which a patient has been shown to be allergic to 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 "shot reactions." These are generally mild and include:

- 1. Generalized hives (welts)*
- 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, tongue or throat, or a sensation of a lump in the throat*
- 5. Stomach or uterine (menstrual-type) cramps*

Occasionally, more severe reactions include wheezing, coughing, shortness of breath or chest tightness.

Rare complications are abnormalities of the heart rate and/or drop in blood pressure. Severe reactions involving the heart, lungs and blood vessels have occasionally been fatal.

It has been shown that patients improve with allergy shots in proportion to the strength of the serum, but also that the incidence of reactions increases with the strength of the serum. It is my philosophy to balance risk versus benefits, to try to get you better and off shots in four to five years, and to minimize the irreducible risk inherent in higher dose therapy as much as possible. To this end, you must receive your allergy shots in a location where a physician, nurse practitioner or physician assistant is present. No patient will be allowed to self-administer shots.

Experience has shown that the overwhelming majority of reactions that require emergency treatment occur within 30 minutes of an injection. It is for this reason that all patients who receive such injections must remain in the office for 30 minutes until checked by a clinic nurse or physician. Anyone leaving prior to this time does so against medical advice. In case you have a reaction after leaving the office, you will be given a prescription for an epinephrine injector and instructions in its use. Have it with you on days when you get your shot. Additionally, all patients should avoid vigorous exercise for 2 hours after receiving their shots.

The overwhelming majority of reactions are mild and easily reversible with treatment with epinephrine and possibly an antihistamine. If you notice any unusual symptoms after your shot, please inform the nurse or doctor IMMEDIATELY. Please do not try to "not bother the nurse" or "be sure" before telling us. Please let us make the decision as to whether some vague symptoms that you may feel are a genuine reaction.

When you first start immunotherapy, you will build to maintenance faster if you can come twice a week, but you must come at least once a week. You will be told when your shot schedule changes. If too much time lapses between shots your serum may expire (it is not good indefinitely) or your vials may need to be diluted. If your serum expires, it will need to be remade which may cause a delay in your shots and extra charges to you or your insurance company. If your serum needs to be diluted there will be a \$10/vial dilution fee that must be paid prior to receiving your shots.

Patients who are on beta-blocker drugs (used for high blood pressure, or other cardiac problems and occasionally migraines) may not receive immunotherapy because beta-blockers block the response to epinephrine. If after being started on allergy shots your primary care doctor considers putting you on a beta-blocker you should inform him or her that either a substitute would have to be found or we will have to discontinue your allergy shots.

In signing this statement, I acknowledge that I have read and fully understand the information that it contains, and that I have been able to have any questions answered by one of the allergy technicians or physicians. By signing this form, I also understand that I have agreed to commence immunotherapy and that extract will be ordered and billed to either my insurance carrier or me, depending on my health care benefits.

PATIENT NAME: _____ PATIENT SIGNATURE _____ Date: _____

PHYSICIAN COUNSELOR: _____ Date: _____

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