Allergen Skin Testing

You are scheduled for allergy testing on: _____at_____.

Please wear a sleeveless, loose fitting or short sleeve shirt for the testing, which can take 1 ½ - 2 hours.

Please complete the attached allergy questionnaire and bring it with you to your appointment. You will review your answers with the allergy nurse and decide what allergens would be appropriate for testing.

Some prescription and over-the-counter medications can interfere with the allergy testing. It is very important that you are off all these medications for the designated time (see next page for list of medications and times). Consult your prescribing physician before you stop taking any heart or blood-pressure medications.

MEDICATION INTERACTIONS:
Do not take any prescription or over-the-counter antihistamines seven days prior to testing. These medications will inhibit the responses we measure in the test results and will give a false reading. Please inform us if you are currently taking antidepressants as these medications may also affect test findings.

You **cannot** be tested for allergies if you are currently taking a Beta-blocker. Beta-blockers are often prescribed for high blood pressure, cardiac problems, eye problems and migraine headaches. If you are currently taking a Beta-blocker, please bring it to our attention as soon as possible.

If you have received a Kenalog injection recently, you must wait 8 weeks from the date of that injection before testing for allergies.

COST:
Please check with your insurance company regarding coverage and payment information for **allergy testing** as the test costs about **$1800.00**. The procedure or CPT codes used for testing are **95004** and **95024** up to **40 units for each code**.

We require allergy patient balances to stay below a $500 threshold. If your account balance goes above that amount, we have the right to suspend allergy treatment until your balance is closer to the threshold amount.

I acknowledge and understand that I will be charged a $150.00 fee for a no show or late cancellation (less than 48 hours).

Please bring this packet back in with you for your allergy testing. The nurse will need this information completed prior to beginning your test.

Medicines to Avoid Before Allergy Skin Testing

If you have any questions regarding your medications, please call our office at (503)-699-0370.

CONSULT YOUR PRESCRIBING PHYSICIAN BEFORE YOU STOP TAKING ANY HEART OR BLOOD PRESSURE MEDICATIONS.

STOP 7 DAYS PRIOR

Antihistamines:

- azelastine (**Astelin, Astepro Nasal Sprays**)
- brompheniramine (**Dimetapp**)
- cetirizine (**Allertec, Zyrtec, Zyrtec-D**)
- chlorpheniramine (**Chlor-Trimeton, Triaminic**)
- desloratadine (**Clarinex**)
- diphenhydramine (**Benadryl ,Diphedryl**)
- doxylamine (**Nyquil, Alka-Seltzer Plus**)
- fexofenadine (**Allegra, Allergra-D**)
- hydroxyzine (**Atarax, Vistanil, Rezine**)
- loratadine (**Allerclear, Alavert, Clartin, Claritin-D**)
- levocetirizine (**Xyzal**)
- olaptadine (**Patanase Nasal Spray**)

Beta Blockers *Contact your PCP / prescribing provider before stopping your medication**

- Acebutolol (**Sectra**l)
- Atenolol (**Tenormin**)
- Betaxolol (**Kerlone**)
- Bisoprolol (**Zebeta, Ziac**)
- Carteolol (**Cartrol**)
- Carvedilol (**Coreg**)
- Labetalol (**Normodyne, Trandate**)
- Metoprolol (**Lopressor, Toprol-XL**)
- Nadolol (**Corgard**)
- Nebivolol (**Bystolic**)
- Penbutolol (**Levatol**)
- Pindolol (**Visken**)
- Propanolol (**Inderal**)
- Sotalol (**Betapace**)
- Timolol ophthalmic solution (**Timoptic, Betimol, Istalol**)

Cold/Flu Medications:

- Tylenol Cold & Sinus, Nyquil, Advil Cold & Sinus

Psychotropic Medications:

- Examples include (but are not limited to) doxepin, imipramine, and amitriptyline

Sleep Aids:

- Advil PM, Nyquil Relief, Nytol, Tylenol PM, Unisom and ZzzQuil

Acid-reflux Medications:

- Cimetidine (TAGAMET), Ranitidine (ZANTAC) and Famotidine (PEPCID)

STOP 3 DAYS PRIOR

BRAND/GENERIC NAME(S):

- Advil **PM**/ Ibuprofen **PM**
- Midol **PMS**
- Prescription Nasal Sprays
    - Astelin/ Azelastine
    - Astepro/ Azelastine
    - Dymista/ Azelastine
    - Patanase/ Olopatadine
- Pataday - Eye Drops
- Tylenol **PM**/ Acetaminophen **PM**
- Visine
- Vitamin C (No more than 500 mg Daily)

Herbal Supplements

- Licorice, Green Tea, Saw Palmetto, St. Johns Wort, Feverfew, Milk Thistle and Astragalus

OKAY TO CONTINUE

- **Regular Tylenol and Advil is OK (**only **PM** needs to STOP**)**
- **Antibiotics**
- **Steroid nasal sprays**: Flonase, Nasonex, Nasacort, Rhinocort, Veramyst, Omnaris, fluticasone
- **Asthma medications:** Albuterol, Flovent, Singulair, Advair, etc.
- **Decongestants:** Sudafed, Prolex D, Mucinex, guiafenesin, pseudoephedrine, phenylephtine
- **Stomach acid reducers:** Protonix, Prevacid, Nexium, Aciphes, Prilosec, omerprazole
- **Medicines for most other conditions** such as diabetes, arthritis, reflux, high blood pressure, cholesterol, cardiac, anticonvulsants, over or underactive thyroid, birth control, insomnia, anxiety, and depression including Ambien, Lunesta, Xanax, Ativan, Valium, Prozac, Effexor, Zoloft, bupropion, Wellbutrin, fluoxetine, sertraline, Celexa, and Lexapro.

Patient History

Patient_____DOB_____ Sex □M □F Physician_____

FAMILY HISTORY (Indicate members of your family who have had an allergic condition)

□ mother □ brother □ grandparent
□ father □ sister □ mother □ father

PATIENT SYMPTOMS (Indicate from the list below your major symptoms)

GENERAL BODY
□ hives
□ rashes
□ aches
□ fever
□ tension
□ fatigue

DIGESTIVE TRACT
□ indigestion
□ diarrhea
□ abdominal pain
□ mucus in bowels
□ gas

HEAD
□ headache
□ watery eyes
□ puffy eyes
□ itchy eyes
□ popping in ears
□ congested nose
□ runny nose
□ itchy nose
□ sneezing

THROAT/CHEST
□ coughing
□ wheezing
□ congested chest
□ shortness of breath
□ sore throat
□ itchy throat

FREQUENCY/TIME AND DURATION OF SYMPTOMS (Check the appropriate response below)

□ sporadic (at various times of the year but with no pattern)
□ persistent (throughout the year)
□ seasonal (indicate the prominent months below)

□ Jan □ Feb □ Mar □ Apr □ May □ Jun
□July □ Aug □ Sep □ Oct □ Nov □ Dec

DURATION □ minutes □ hours □ days
TIME OF DAY □ morning □ afternoon □ evening □ after meals

SURROUNDINGS (Indicate where/when symptoms occur below)

OUTDOORS
□ after mowing lawn
□ in damp areas
□ while driving
□ while taking walks
□ while exercising
□ near burning leaves
□ near farms/barns

INDOORS
□ in basement/crawl space
□ after dusting/vacuuming
□ at school
□ at work (if checked indicate occupation)
□ after exercising

INDOORS (con't)
□ in bedroom
□ in kitchen
□ in attic

_____

TYPE/LOCATION OF HOME
□ single family
□ apartment/condominium
□ mobile home
□ in city
□ in suburbs
□ in heavily wooded area
□ in farming area

HEATING SYSTEM
□ forced air
□ electric
□ oil
□ coal
□ radiant

COOLING SYSTEM
□ air conditioner
□ oscillating fan(s)
□ ceiling fan(s)

BEDROOM (Indicate which items below are found in your bedroom)

□ carpet
□ vinyl or wood floors
□ drapes
□ vertical blinds
□venetian blinds
□ dehumidifier
□ cotton pillow
□ feather pillow
□ foam rubber pillow
□books
□stuffed animals
□fans (ceiling or oscillating)
□ air conditioner (if checked see below)
□ central
□ individual unit
□ cotton mattress
□ feather mattress
□ foam rubber mattress
□ waterbed mattress

PETS

□ own pet(s) If checked, indicate the pet(s) below
□ visit home/farm that has pets. If checked, indicate the pet(s) below

□ cat □ bird □ other (list below)
□ dog □ hamster
□ horse □ rabbit _____

INSECT BITES

Yes	No	
□	□	Have you ever had a severe reaction to insect bites?
□	□	Have you been stung by an insect within the last six months?

If you checked yes to either question above, indicate the insect:

□ wasp □ tick □ ant
□ hornet □ flea □ other (list below)
□ yellow jacket □ mosquito
□ honey bee □ spider _____

MEDICATIONS (Check any medications that you are presently taking)

□ aspirin □ vitamins
□ corticosteroids □ nose drops/sprays
□ sedatives □ hormones
□ birth control □ other (list) _____

Yes	No	
□	□	Are you or do you think you are allergic to any drugs? If yes, list below.

_____

CONTACTANTS (Indicate any substance below that may cause your symptoms or make them worse)

□ laundry soap □ shampoo □ cosmetics
□ dish detergent □ cotton □ newspapers/magazine print
□ hand soap □ perfume/cologne □ wool

DIETARY INFORMATION (Indicate how often you eat the following foods)

	Daily	Weekly	Rarely	Never		Daily	Weekly	Rarely	Never
□ milk	□	□	□	□	□ beef	□	□	□	□
□ eggs	□	□	□	□	□ tuna	□	□	□	□
□ wheat(bread)	□	□	□	□	□ codfish	□	□	□	□
□ corn	□	□	□	□	□ rice	□	□	□	□
□ chocolate	□	□	□	□	□ cereals	□	□	□	□
□ peanuts	□	□	□	□	□ potato	□	□	□	□
□ orange	□	□	□	□	□ peas	□	□	□	□
□ soybean	□	□	□	□	□ beans	□	□	□	□
□ pork	□	□	□	□	□ List foods below that you think give you trouble:				

_____

MISCELLANEOUS (Please answer the following questions)

Yes	No	
□	□	Do you smoke?
□	□	Does anyone else in your household smoke?
□	□	Are you exposed to unusual fumes at work or home? If yes, list below:

_____

□	□	Are you presently under any unusual form of stress?
□	□	Have you ever been treated for allergies before? If yes indicate type of treatment:

□ antihistamines □ corticosteroids □ immunotherapy (allergy injections)

Effectiveness of treatment: □ poor □ fair □ good

Allergen Skin Testing
Consent

Allergies are the result of the body's abnormal response to normally harmless substances (allergens). The body can produce symptoms such as runny nose, recurrent fluid in the ear, nasal congestion, recurrent sinus congestion and infections, headaches, hives, asthma, stomach complaints, itchy eyes, and skin conditions in response to allergens.

You will be tested for specific allergens that are airborne in the area in which you live. The allergens you are tested for are based on your symptoms and your responses to the patient history questionnaire you were given. The allergens tested usually include pollens, dust, molds, and animals. Since some of the pollens are more allergenic than others, the ones that are most allergenic and prevalent in this area are tested. Pollens include trees, grasses, and weeds. Molds are microscopic plants that grow on any organic matter (leaves, wood, food, paper, leather, etc.). Mold spores are very tiny and lightweight, making them readily airborne and widely scattered. Dust mites are the allergic component of house dust. They feed on human dander and are found in abundance in mattresses and pillows. Dust mites are a year-round allergen. You will be tested for animal dander based on your exposure to certain animals. Animal dander is a year-round allergen.

Allergy testing and treatments are a way of controlling your allergy problem and is not a cure. Treatment is aimed at improving your symptoms by habituating your immune system and decreasing the need for medications. Testing provides us with the information needed to start therapy at a level specific to your reactivity to certain allergens. Testing is started at a low concentration of allergen and gradually built up to a higher concentration based on your response. Once a positive reaction occurs, that allergen is no longer tested, and your treatment level is established.

I acknowledge that I have read the above information, and I agree to allergy testing.

_____

Patient Name (please print)

_____

Patient Signature Date

_____

Parent or Guardian Signature Date
(if patient under the age of 18)

Allergen Skin Testing
Financial Policy

The following diagnostic services may or may not be covered under your insurance plan:

Allergen Skin Testing

I acknowledge and understand that I will be charged a $150.00 fee for a no show or late cancellation (less than 48 hours).

I understand that allergy testing may or may not be covered for payment by my insurance plan. If I or my child elects to be tested for allergies, I agree to be personally responsible for any balance if not paid by the insurance plan. I understand my insurance may cover allergy testing, but it may apply to deductible. The estimated cost of the allergy test is about $2,000.00.

Allergy shot coverage will vary greatly among insurance companies and plans. Once a reimbursement amount has been established, that will be your allergy shot co-pay or could apply to deductible. If it is a co-pay the co-pay will be required prior to allergy shot being administered.

I agree to keep my account balance at or below the $500 threshold and am aware that treatment can be suspended if I fail to do so.

If SLIT Vials are preferred at $130.00 per vial, SLIT vials are not covered by insurance. The vial will need to be paid at time of ordering.

I acknowledge that I have read the above information and understand that I will be charged a $150.00 fee for a no show or late cancellation (less than 48 hours).

_____

Patient Name (please print)

_____

Patient Signature Date

_____

Parent or Guardian Signature Date
(If patient under the age of 18)

If you have any questions regarding the estimated cost of the testing, please call our office at 503-699-0370.