ALLERGEN IMMUNOTHERAPY– DISCLOSURE AND CONSENT
THE TANKERSLEY CLINIC

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ALLERGY, RESPIRATORY AND SKIN CARE

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended allergen immunotherapy (allergy shots) to be used so that you may make a decision whether or not to undergo the allergy shots after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the allergy shots.

1. I voluntarily request Dr. Mike Tankersley, as my Allergist, and such associates, technical assistants, and other health care providers as necessary, to treat my condition which on the basis of my allergy evaluation has been explained to me as:
   - allergic rhinitis with or without conjunctivitis and/or
   - asthma which is triggered by allergy and/or
   - atopic dermatitis (eczema) and/or
   - venom allergy
2. I understand the following medical procedure is planned for me and I voluntarily consent and authorize: allergen immunotherapy, also known as allergy shots or subcutaneous immunotherapy (SCIT).
   a. **How do allergy shots work?** Research has shown that allergy shots decrease allergic reactions by stimulating the formation of protective "blocking antibodies", by decreasing the production of "allergic antibodies", and by altering other immune cell function in a beneficial way.
   b. **How often and how long must I receive allergy shots?** Allergy shots are given once or twice a week in increasing doses until a maintenance dose is reached. Once reaching maintenance, shots are generally given once a month. However, allergy shot maintenance intervals are individualized and can vary between every two weeks to monthly. Once a year a new maintenance vial will be made and the maintenance dose will be decreased 50% with a build-up for five visits required back to maintenance. The duration of treatment with allergy shots will depend on how well you tolerate them and how well you respond to treatment. In general, an 18-month trial is given, and if benefit is realized, the shots are continued for 3-5 years with follow-up appointments several times in the first year and then at least every 6-12 months thereafter with Dr. Tankersley.
4. I understand that no warranty or guarantee has been made to me as to result or cure.
5. Just as there are risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of allergy shots. I realize that common to allergy shots is the potential for allergic reactions and even death. I also realize the risks which may occur in connection with allergy shots include but are not limited to:
   a. Local reactions with itching, redness, warmth, swelling and tenderness at the injection site. Swelling may at times extend down to the elbow. Doses are generally not adjusted for local reactions unless they are bothersome to the patient and then other measures can be used to alleviate the local reactions.
   b. Generalized reactions may include hives; itching of the eyes, nose, and/or skin; swelling of the face, throat, hands and/or feet; wheezing and difficulty breathing; nausea, vomiting, diarrhea and/or abdominal cramps; rapid heart rate; lightheadedness and/or sudden drop in blood pressure; and rarely death. Historically, there are two deaths per year in the US related to allergy shots. These generalized reactions can usually be easily reversed if treated early, but they can be life-

threatening without immediate medical attention. For this reason, we ask you to remember and adhere to the following:

i. Your shots should be given at a medical facility capable of treating an allergic reaction with supervision by either a physician or mid-level provider (nurse practitioner and/or physician's assistant).
ii. Remain for 30 minutes in the designated waiting area following each shot visit.
iii. Report any symptoms immediately.
iv. Report any reaction, local or generalized, before you receive your next shot.
v. Notify Dr. Tankersley if you become pregnant. With few exceptions allergy shots can be continued (not increased) during pregnancy (discuss with Dr. Tankersley).
vi. Notify Dr. Tankersley if you are started on any new medications, especially a beta-blocker medication (used for high blood pressure and migraine headaches). With very few exceptions allergy shots cannot be started and must be stopped if you are on a beta-blocker.
vii. If you have asthma, do not receive an allergy shot if you have had active asthma symptoms in the last 24 hours.
viii. Take an oral antihistamine (e.g. Allegra, Claritin or Zyrtec) the morning of or evening before when you will receive your allergy shot.

6. I understand there may be alternatives to the allergen immunotherapy. Alternatives include but are not limited to: tolerate/ignore the allergy symptoms, environmental control measures to avoid exposure to things to which I am allergic, oral medication such as antihistamines and decongestants taken on an as needed or daily preventative basis, anti-allergy eye drops, anti-allergy nose sprays, anti-asthma inhalers and/or sublingual immunotherapy (SLIT) for grass, ragweed or house dust mite.
7. Just as there may be risks and hazards to allergy shots, I also realize that risks and hazards may occur in connection with the alternatives and include but are not limited to: ongoing allergy and/or asthma symptoms, missed school/work due to symptoms, diminished quality of life and/or work performance, and/or side effects from medications.
8. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures to use, and the risks and hazards involved, and I have sufficient information to give this informed consent.
9. I understand my extract, the mixture of allergens with which I will be treated, will be made in the coming week, and once made, cannot be used for any other patient. Therefore, I will be billed for this extract even if I should decide not to take the injection treatment.
10. I certify this form has been fully explained to me, the blank spaces here have been filled in, and I have either read it or had it read to me, and I understand the contents

Date: _____/_____/_____

Name of patient/other legally responsible person: _____

Signature of patient/other legally responsible person: _____

Name of Patient (if different from legally responsible person): _____

Date of Patient Birth: _____

Signature of counseling physician: ___Mike Tankersley, M.D. MBA_____
Name of counseling physician: Mike Tankersley, MD, MBA, FAAAAI, FACAAI, FAAP