Name: _____
MRN: _____DOB: _____

Consent for Allergy Testing

1. Consent: I _____ [patient name] consent to have my provider 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/back 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 60-90 minutes. The test carries a 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 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.

4. Risks, Benefits, Alternatives to Allergy Testing. After talking with my provider, 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 provider I was taking
    - Shock (anaphylaxis), which is a serious reaction, which can lead to death. Signs and symptoms of shock are:

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- Difficulty breathing, shortness of breath, wheezing or high pitched breathing sounds
- Feeling of 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 done by doing in vitro testing (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 can be 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.

Alternative treatment options may include:

- Oral medications such as antihistamines (zyrtec), leukotriene inhibitors (singulair), steroids (like prednisone)
- Nasal sprays such as antihistamine (azelastine) or steroid (fluticasone)

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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 provider about all the medicines, vitamins, and herbs that I am taking before I get allergy testing because they could put me more at risk for 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 prescribing provider if I do not know if I am taking a beta blocker. I understand that a beta-blocker must be stopped under the direction of my prescribing provider and will be at least 7 days prior to allergy testing.

   I understand that I must tell my provider before I get my allergy test if I have asthma or feel any asthma-like symptoms; such as chest cold symptoms, chest tightness, shortness of breath, cough. Any of these symptoms could put me at risk of a serious reaction or even shock (anaphylaxis).

   I understand that exercising hard before (less than 2 hours) or 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 testing, I will tell my provider right away. I will not leave the office until I have been cleared by my provider to leave. I will get treatment or medicines needed to help me, such as benadryl, prednisone, epinephrine (medicine to help me if I have a reaction) as recommended by my provider. If epinephrine is used in the office, I understand that 9-1-1 will be called to transport me to the emergency room where I will need to be under observation. An anaphylactic reaction may reoccur up to 6 hours later.

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);
   - It's risks;
   - It's benefits;

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- Any alternative procedures and/or treatments, including the risks of those alternatives, if any;
- The options of non-treatment including 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: _____

Witness Signature: _____ Date: _____

Provider Declaration:
I have discussed the procedure as detailed above including the possible risks, benefits, complications, alternative treatments and associated risks, (including non-treatment) and anticipated results. I have answered all of the patient's (or guardian's/authorized representative) questions that were asked. The patient (or guardian/authorized representative) indicated that they have been adequately informed and agrees to the procedure.

Provider Signature: _____ Date: _____