MARK E. KAPLAN, M.D. • STACIE A. McMURTRY, M.D. • SANDRA DENMAN, PA-C

ALLERGEN IMMUNOTHERAPY PATIENT CONSENT FORM

Our office maintains policies and procedures for the administration of immunotherapy (allergy injections). When initiating a course of immunotherapy, it is vital that the patient and family clearly understand all aspects of this therapy.

Immunotherapy must be administered at a medical facility with experienced, trained professionals present as occasionally, reactions may require immediate treatment. In most cases, there is no reaction to the injection or a minimal amount of redness, itching or swelling at the injection site. However, on very rare occasions, more severe reactions may occur. These reactions may consist of any of the following symptoms: itchy eyes, nose, or throat; nasal congestion, sneezing or runny nose; tightness in the throat or chest; coughing and wheezing; lightheadedness; nausea and abdominal discomfort; hives, swelling or generalized itching. In extremely rare cases, reactions can be fatal.

For these reasons, **you are required to wait in the medical facility in which you receive the injections for 30 minutes after each immunotherapy session.** If the patient is 15 years of age or younger, a parent or legal guardian must be present during the waiting period. Patients ages 16-17 may receive their injections independently with written permission from a parent or guardian.

I understand that every precaution consistent with the best medical practice will be carried out to protect me against adverse reactions from immunotherapy. I also agree that if I have an allergic reaction to the injections, the medical staff has my permission to treat this reaction.

I have read and understand the patient information sheet on immunotherapy. The opportunity has been provided for me to ask questions regarding the potential side effects of immunotherapy and these questions have been answered to my satisfaction.

I authorize the office to bill for allergen material, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the material has been formulated. I have had the opportunity to discuss billing concerns with my insurance provider, and have obtained, if applicable, the requisite authorization from my primary care provider and insurance plan.

_____

Patient Name (print)

_____ _____

Patient/Parent/Guardian Signature Date

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