IMMUNOTHERAPY INFORMED CONSENT

Patient's Name: _____ DOB: _____

I have discussed the need for allergy injections with the practitioner at our office visit as a treatment for my allergic condition. I received patient information describing allergy immunotherapy which is made part of this consent by reference. Alternate forms of treatment including the use of environmental control measures and allergen avoidance and treatment with prescription medications were also discussed. The potential side effects caused by allergy injections have been explained to me.

I understand that they include, but are not limited to, localized swelling at the injection site and the possibility of a systemic reaction. A systemic reaction can vary from minor symptoms (itchy throat or eyes, runny nose, sneezing) to a more severe reaction (wheezing, chest tightness, hives, difficulty swallowing). Although rare, patients may have more severe reactions, including drop in blood pressure, shock and rarely death.

As most severe reactions to allergy injections occur within the first 30 minutes after receiving an injection, I understand I must wait in the office at least 30 minutes following an injection. I will report any generalized or systemic reactions immediately to the physician, even if this occurs after leaving the office, so that appropriate treatments to relieve the reaction may be given. While treatment for a reaction that occurs during the waiting period is administered in the office, a severe reaction may require more advanced treatment. I acknowledge the fact with my signature that I am authorizing the office to bill for allergen vaccines, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the vaccine has been made. Vaccines may be prepared weeks prior to initiating the actual in-office start of treatment.

- ☐ I acknowledge that I have been instructed in the use of an epinephrine auto-injector and have been issued a prescription for this item.
- ☐ I acknowledge I have been educated in self-injection of immunotherapy and understand the potential risks.
- ☐ I acknowledge that I am being prescribed an injectable immunotherapy program that will be billed to my health insurance which may use CPT codes such as 95165 and/or 95144 (info available at www.cms.gov).

(ONLY if taking a beta blocker)

- ☐ **I acknowledge that I am presently taking beta-blocker medication**. I understand that these medications are commonly used to treat high blood pressure, arrhythmias, heart palpitations, tremors, glaucoma and migraine headaches.
- ☐ **Beta-blockers may increase my risk for a potentially serious systemic reaction from Allergy Immunotherapy that is resistant to treatment.**[1,2,3]

In signing this consent, I acknowledge that I have read and understand the above information, the additional risk factors that may be present as described above and that my practitioner has satisfactorily answered my questions.

Patient Name _____ Patient Signature _____

Date _____

*This document should not be construed as medical advice which can only come from a licensed provider. All medical questions should be directed to your licensed provider.

1) Coop CA, Schapira RS, Freeman TM. Are ACE Inhibitors and Beta-blockers Dangerous in Patients at Risk for Anaphylaxis? *J Allergy Clin Immunol Pract*, 2017; 5(5): 1207-11.

2) Lieberman P, Nicklas RA, Randolph C, Oppenheimer J, Bernstein D, Bernstein J, et al. Anaphylaxis—a practice parameter update 2015. *Ann Allergy Asthma Immunol* 2015;115:341-84.

3) Cox L, Nelson H, and Lockey R. Allergen Immunotherapy: A Practice Parameter Third update *J Allergy Clin Immunol*, 2011;127 (1): s1-s49.