rev 07/2014

Patient Information/Consent Form for Allergy Skin Testing

Name _____ Chart #_____ DOB _____

PLEASE READ AND BE CERTAIN THAT YOU UNDERSTAND THE FOLLOWING INFORMATION PRIOR TO SIGNING THIS CONSENT FOR TESTING

PURPOSE

Allergy Skin Testing is a method of testing for allergic antibodies. Allergic antibodies are produced by your immune system after repeated exposure to allergic substances (e.g. pollen, cat dander). Not all people have allergic antibodies and not everyone with allergies will produce antibodies to all allergic sources. Allergy skin testing helps to confirm which substances (if any) may be causing your allergic symptoms.

The results of the skin tests will be correlated with your clinical history and description of allergy symptoms. Positive tests indicate the presence of allergic antibodies, but a positive skin test result does not necessarily indicate that the allergen will cause symptoms.

METHOD

The allergy skin test method used in this clinic is Skin Prick Method where the skin is pricked with a disposable plastic applicator that delivers a very small amount of allergenic extract into the skin surface. Each applicator tests eight (8) allergens and as many as six (6) applicators will be applied to either your arms or back. No needles are used in this method.

ALLERGENS

You will be tested to a variety of important airborne allergens. These include pollen (from trees, grasses, & weeds), molds, dust mites, and animal dander. The allergens in your testing panel represent the most common inhalant allergens for your region as well as many common allergens found in residential and work environments. No food allergens are included in this panel. If you believe that you have a specific food allergy, you should ask your physician whether consulting a specialist is recommended.

EXPECTATIONS

An allergy skin test consists of introducing small amounts of the suspected allergic substance (i.e. allergenic extract) into the skin and noting the development of a positive reaction which consists of mild swelling and redness (similar to a mosquito bite). The procedure takes less than 10 minutes to administer and the results are read approximately 15 to 20 minutes after the application of the allergen.

Any positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. Most patients report the procedure to be pain free though you may feel a pricking sensation during the application of allergen, and many patients will experience some itching. The testing nurse will provide a cream or spray to help relieve itching after the test results have been recorded. In rare cases, some local swelling may occur several hours after the skin tests are applied. These reactions are not serious and will disappear over the next week or so. They should be measured and reported to your physician at your next visit.

MEDICATIONS TO AVOID

1. No prescription or over the counter oral antihistamines should be used 4 to 5 days prior to scheduled skin testing. These include cold tablets, sinus tablets, hay fever medications, or oral treatments for itchy skin, over the counter allergy medications, such as Claritin, Zyrtec, Allegra, Actifed, Dimetapp, Benedryl, and many others. Prescription antihistamines such as Clarinex and Xyzol should also be stopped at least 5 days prior to testing. If you have any questions whether or not you are using an antihistamine, please ask the nurse or the doctor.
2. Medications such as over the counter sleeping medications (e.g. Tylenol PM) also contain active ingredients that interfere with histamine and these should not be taken within 3 days of your scheduled skin test.
3. You should discontinue your nasal and eye antihistamine medications, such as Patanase, Pataday, Astepro, Optivar, or Astelin at least 2 days before the testing.
4. Other prescribed drugs, such as amytriptyline hydrochloride (Elavil), hydroxyzine (Atarax), doxepin (Sinequan), and imipramine (Tofranil) have antihistaminic activity and should be discontinued at least 2 weeks prior to receiving skin test. Do not stop taking these medications before consulting with your physician first.

MEDICATIONS TO BE CONTINUED

1. You may continue to use your intranasal allergy sprays such as Flonase Rhinocort, Nasonex, Nasacort. Omnaris, Veramyst and Nasarel.
2. Asthma inhalers (inhaled steroids and bronchodilators), leukotriene antagonist s (e.g. Singulair, Accolate) and oral theophylline (Theo-Dur,T-Phyl, Uniphyl, Theo-24, etc.) do not interfere with skin testing and should be used as prescribed.
3. Most drugs do not interfere with skin testing but make certain that your physician and nurse know about every drug you are taking (bring a list if necessary).

ADVERSE REACTIONS

Although adverse reactions to skin testing are rare, your test will be administered at this medical facility with a medical physician or other health care professional present since occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances. Please let the

physician and nurse know if you are pregnant or taking beta-blockers.

Allergy skin testing may be postponed until after the pregnancy in the unlikely event of reactions to the allergy testing and beta-blockers are medications they may make the treatment of the reaction to skin testing more difficult.

Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.

ADDITIONAL INFORMATION

After skin testing, you will consult with your physician or other health care professional to discuss further recommendations regarding your treatment.

We request that you do not bring small children with you when you are scheduled for skin testing unless they are accompanied by another adult who can sit with them in the reception room.

Please do not cancel your appointment since the time set aside for your skin test is exclusively yours for which special allergens are prepared. If for any reason you need to change your skin test appointment, please give us at least 48 hours notice, due to the length of time scheduled for skin testing, a last minute change results in a loss of valuable time that another patient might have utilized.

IMPORTANT MEDICATIONS TO INFORM US IF YOU ARE TAKING

Beta –blocker: Examples: Lopressor [metoprolol], Coreg [carvedilol], Tenormin [atenolol], some glaucoma eye drops.

Some antidepressants or Monoamine oxidase inhibitor.

OTHER IMPORTANT INFORMATION

- Fasting is not necessary, but please avoid sunburns or excessive sun exposure immediately before allergy testing.
- Please bring in a list of your current medications
- Please let us know if:
    - You are or possibly are pregnant
    - Wheezing or have a fever

CONSENT FOR ADMINISTRATION OF ALLERGY SKIN TESTING (SKIN PRICK TEST)
AUTHORIZATION FOR TESTING

I have read the information in this consent form and understand it. The opportunity has been provided for me to ask questions regarding the potential risks of allergy skin testing, and these questions have been answered to my satisfaction. I understand that precautions consistent with the best medical practices will be carried out to protect me from adverse reactions to skin testing. I do hereby give consent for the patient designated below to be tested with allergenic extracts by skin prick testing, as recommended by a physician.

_____	_____
Printed Name of Immunotherapy Patient	Medical Record Number
_____	_____
Patient Signature (or Legal Guardian)	Date Signed
_____	_____
Witness	Date Signed

FOR OFFICE USE ONLY:

I certify that I have counseled this patient and/or authorized legal guardian concerning the information in this Consent for Allergy Skin Testing and that it is my opinion that the signee understands the nature, risks, and benefits of the proposed diagnostic procedure.

_____	_____
[Physician Name]	**Date Signed**

Ohio Valley Optimal Healthcare
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