IMMUNOTHERAPY INFORMATION AND CONSENT FORM

Patient's Name: _____ Acct. No: _____ Doctor: _____

Your physician has recommended immunotherapy (allergy injections - shots) as a form of treatment for you or your child. It is important to understand the nature of this treatment, how it works and the possible side effects.

WHAT ARE ALLERGY SHOTS?

Allergy shots, or immunotherapy, are the process by which an allergy patient is made less sensitive to a specific allergen (such as pollens, house dust mites, and animal dander and mold spores). This reduction in sensitivity is accomplished by injecting increasing doses of mixtures of these substances into the upper arms. Improvement is not seen immediately and may not be apparent for up to one year. The results are usually a significant reduction, but not complete elimination of symptoms and the need for less medication. Approximately 80%-90% of allergic individuals who undergo immunotherapy will see a significant reduction in symptoms.

HOW OFTEN DO I RECEIVE SHOTS?

Immunotherapy injections are usually given once or twice a week. It can take three to six months (or occasionally longer) to reach a top or maintenance dose. You are required to receive your injections in our office. Most patients begin to experience relief of their symptoms after reaching the maintenance dose. The interval between injections can slowly be decreased to every two weeks, then every three weeks and eventually every four weeks. The total duration of a course of immunotherapy is usually four to five years.

CAN REACTIONS TO THE SHOTS OCCUR?

Because you or your child will be receiving injections of substances to which you/they are allergic, reactions to the injections can occur. Most often, reactions are limited to swelling, itching or redness at the site of the injection. Small reactions less than dime-size are not unusual. There are also rare chances of bruising under the skin causing mild discomfort. You should discuss the size and severity of local reactions with the nurse prior to the next injection. Although this is rare, reactions may occur involving other parts of the body including generalized itching or hives, increased nasal congestion, sneezing or runny nose, shortness of breath, tightness in the chest or throat, or wheezing. Reactions can be serious, but rarely fatal. Most reactions occur within 30 minutes but may occur up to 6 to 12 hours after the injection(s). You must notify the doctor or nurse immediately if any systemic symptoms occur so that proper treatment can be initiated. You should not receive your allergy immunotherapy injection(s) if you have been ill with a fever, wheezing; have hives or severe nasal allergy symptoms. You should avoid strenuous exercise for approximately two hours after receiving your injections(s).

WHAT OTHER PRECAUTIONS SHOULD I TAKE?

Patients taking immunotherapy injections should not use beta-blocker medications because of an increased risk of having a more severe allergic reaction including asthma and lowering blood pressure leading to difficulty in treating the reaction. If you are taking a beta-blocker, you must discuss this with the physician prior to initiating the injections. Beta-blocker medications include Betagan, Betoptic, and Timoptic eye drops and Acebutolol, Atenolol, Betaxolol, Bisoprolol, Carvedilol, Corgard, Inderal, Labetalol, Lopressor, Metoprolol, Nadolol, Nevibolol Pindolol, Propanolol, Sectral, Timolol, Trandate and Visken. Patients receiving immunotherapy should also not use MAO inhibitor drugs such as Nardil, Parnate and Marplan. These drugs may cause high blood pressure when used in conjunction with adrenalin, other allergy prescriptions, or over-the-counter allergy medications.

Allergy injections are not to be self-administered and must be given under a physician's supervision. I fully understand the above explanation and give Dr. _____ and his/her staff my permission to make antigen for myself or my child and to administer immunotherapy injections to myself or my child. I understand the need and requirement to remain in the physician's office for 30 minutes after receiving an allergy injection(s). ***I understand if the antigen is made and I do not start shots, I will be responsible for the antigen costs since this is not covered by Insurance.***

_____ _____

Signature Date

Emergency Contact: _____ Phone: _____

CONSENT TO TREATMENT:

The undersigned hereby consents to the care and treatment now and in the future of the patient listed below.

Please Print Patient's Name _____

_____

Signature of Patient, Parent, or Legal Guardian Relationship