I N D I A N A
ALLERGY & ASTHMA

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PATIENT CONSENT FORM
ALLERGY IMMUNOTHERAPY*NEW* (ALLERGY INJECTION THERAPY)

Patient Name: _____ Date _____

Person Administering Consent: _____

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

1. I understand that allergy immunotherapy (allergy injection therapy) is the process by which an "allergic" patient is made less sensitive to a specific allergen (for example, pollens, animal dander, mold spores, dust mite). This reduction in sensitivity is accomplished by repeated injections beneath the skin of the upper arm of increased doses of extracts (mixtures) of these allergens. It is considered a common treatment for allergic diseases.
2. I understand that allergy immunotherapy injections are usually given once or twice a week. Once the highest dose is attained (which may take several months), the frequency may be decreased to once a week, twice a month, or once monthly. The total duration of immunotherapy is usually three to five years. I understand that I should make myself available for periodic assessment by my physician in order to allow my physician to determine if the therapy should be continued or altered.
3. Generally, I understand that I should not receive an injection if I am having a fever, wheezing, or hives. I also should not receive an injection if my asthma is under poor control as evidenced by decreased peak flows, usually less than 70% of my best peak flow readings (yellow/red zone).
4. I am required to be observed for a period of at least 30 minutes (45 minutes for 1st injection) following an injection in a medical setting. I also understand that I must report any problems that I might recognize or suspect as resulting from an allergy injection to the staff of this office **BEFORE** receiving any additional allergy injections. (Please note that this recommendation is for your safety and if you are not agreeable with wait time please make an appointment with Dr. Pooja Patel to discuss your concerns)
5. Myself or my child will be receiving injections of environmental allergens to which I/ my child are allergic to. Reactions to the injections may occur and we must be informed if any of them happened. It is not unusual for swelling and itching to occur at the site of an injection. Occasionally other reactions may occur. These reactions include: generalized itching, hives, fainting, shortness of breath, or tightness in the throat or chest. I recognize the possibility that life-threatening reactions could occur such as anaphylaxis, shock, and death, and although rare, a few such cases have occurred in adults and children. Myself or my child will avoid strenuous exercise for two hours after allergy injection therapy to minimize chance of reaction.
6. PREGNANT PATIENT: Please inform us if you are pregnant. In general we will no start injections on someone who is pregnant but we can continue them (usually at a lower dose) if you become pregnant while on injections
7. BETA BLOCKER: I understand that allergy injections cannot be given to patients who are currently taking beta-blocker medications. If you are on beta blocker medication clearance to hold beta blocker night before

and day of allergy injections will need to be obtained. I understand that I will consult my physician if any changes are made in my medication regimen once allergy immunotherapy is initiated.
Examples of beta-blockers include, but are not limited to Inderal, Lopressor, metoprolol, atenolol, Coreg, Toprol, and propranolol. Beta-blockers may be given for a variety of conditions including hypertension (high blood pressure), angina (heart pain), thyroid disease, arrhythmias (abnormal heartbeat), certain psychiatric disorders (panic attacks), and glaucoma (elevated eye pressure). I understand that you should consult your physician or pharmacist regarding any uncertainty about a specific medication that I may take.

8. If allergy injections are received OUTSIDE of THIS office and administered at another medical facility, we believe that the person or physician administering the injection must assume complete responsibility for any side effects or adverse reactions resulting from the allergy injection. You will need to inform us where you will be getting shots

FINANCIAL RESPONSIBILITY: I understand that allergy immunotherapy serums are prepared under rigidly controlled conditions by trained medical personnel. I will contact my insurance company to inquire about allergy immunotherapy serum preparation (95165) and shot administration (95115 or 95117) to understand service coverage. Our office prepares your serum vials 1 year at a time in bulk to ensure optimal quality, consistency, and safety per practice parameters set forth by the American Academy of Asthma, Allergy, and Immunology (AAAI™). Our billing practices will reflect these guidelines, which may result in multiple serum preparation invoice submissions based on your insurance coverage. If you elect to discontinue allergy immunotherapy, we will not be able to issue a refund for already prepared serum, but can transfer it to another physician. Please discuss any questions you may have with our biller.

Initials of Patient/Parent/Guardian: _____

PATIENT'S CONSENT: I have read and understand this form and consent to be treated with allergy injection therapy. I understand that I should not sign this form if all items, including all of my questions, have not been explained or answered to my satisfaction or if I do not understand any of the items or words contained in this consent form. If you have any questions concerning the proposed treatment, ASK YOUR DOCTOR NOW BEFORE SIGNING this consent form.

DO NOT SIGN THIS CONSENT FORM UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND ITS CONTENTS.

☐ **Yes, I elect to undergo allergy injection therapy.**

☐ **No, I decline to undergo allergy injection therapy.**

Print Name of Patient/Parent/Guardian: _____

Signature of Patient/Parent/Guardian: _____ **Date:** _____