Willamette ENT
Allergy Center

Informed Consent for Allergy Testing

Name ______________________________

Date of Birth ______________________________

The following has been explained to me in general terms and I understand:

- The diagnosis requiring this procedure is allergic rhinitis, which may lead to frequent congestion, headaches, sinus infections, ear problems, etc.
- The nature/purpose of this procedure is identify allergens that you may be sensitive to.
- **Material risks of the procedure:** As a result of this procedure being performed, there may be material risks of allergic reaction, skin rash, bronchial asthma, delayed reaction, diarrhea, headache, arm reaction, angioedema/severe swelling of a body part, severe muscle weakness/paralysis (e.g., Guillian Barre syndrome), severe breathing problems/respiratory arrest, very low blood pressure/anaphylactic shock or death.
- Practical alternatives to this procedure include: antihistamines and other medical treatments.

PROCEDURE

Skin testing is a method of detecting "allergic antibodies" in the system that may be a cause of allergy symptoms. A test consists of introducing a small amount of the suspected substance, or "allergen," into the skin and noting the development of a positive reaction (which consists of a wheal). The results are measured 10 to 15 minutes after the application of the antigen. The skin test methods to be used are checked below:

- ☐ Intradermal Method: This method consists of injecting small amounts of an allergen into the superficial layers of the skin using a small syringe and needle.
- ☐ Multi-Test II Method: Allergen solutions are placed on the individual prongs of a multi-prong plastic device, which is firmly placed on the skin for three to five seconds, then removed, leaving behind the allergen solutions and punctures.
- ☐ Prick Method: A needle is used to prick the skin, where a drop of allergen has already been placed.

Interpreting the clinical significance of skin testing requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergenic antibodies, but are not necessarily correlated with clinical manifestations.

You will be skin tested to important airborne allergens from the Willamette valley. These include trees, grasses, weeds, molds, dust mites, cockroach allergen, animal danders and additional designated allergens based on your personal history if needed. The tests will be placed on your arms. If you have a specific allergic sensitivity to an allergen, a red, raised, itchy wheal (caused by release of histamine into the skin) will appear on your skin within 10 to 20 minutes. These positive reactions will generally fade and disappear over a period of 30 to 60 minutes and typically no treatment is necessary for this itchiness. Occasionally, local swelling at a test site will begin four to eight hours after the skin tests are applied, particularly at sites of intradermal tests. These reactions are not serious and will disappear over the next day or two. They should be measured and reported to the office nurse by phone or during your next visit. Your physician or their staff will discuss with you the specific items to which you will be tested prior to any application of tests.

I understand the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history and other information in determining whether to perform allergy testing and treatment.

I understand the practice of medicine is not an exact science and **no guarantees or assurances have been made to me** concerning the results of this procedure.

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I understand during the course of the procedure described herein, it may be necessary or appropriate to perform additional procedures that are unforeseen or are not known at the time this consent is given. Since these testing materials are derived from substances to which you may be allergic, there is a small risk a generalized ("systemic") reaction may result. Such a reaction might include generalized itching, nasal congestion or drainage, throat tightness, cough or difficulty in breathing; these reactions could potentially progress to a life-threatening situation if not recognized and treated. Should you experience any unexpected symptoms or sensations during your testing, please inform the nurse and appropriate measures will be taken to counteract the reaction. Occasionally, transport to a local emergency room is necessary (you will be billed for this). I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they deem necessary or appropriate.

PRECAUTIONS

Prior to the placement of the skin tests or shots, please let the nurse and your doctor know:

- If you are using any new prescription medication, particularly medication for high blood pressure, migraine headaches or glaucoma.
- If you are pregnant.
- If you are having active asthma problems.
- If you are experiencing wheezing or tightness in your chest, even if you have never been diagnosed with asthma.
- If you are running a fever more than 100°.
- If you are experiencing an allergy flare-up. If you have extreme sneezing, watery eyes or any other common allergy symptoms.
- If you have just finished cutting the lawn, working in the garden or doing housework such as dusting or vacuuming.
- If you have just finished or are about to begin exercising.
- If you have had an extremely stressful day or are under high levels of stress.
- If you have bronchitis, pneumonia or an acute illness.
- If you have hives, shingles or are currently recovering from exposure to poison ivy or poison oak.

After skin testing is completed, the results will be discussed with you and further recommendations will be made regarding your allergy treatment.

I authorize members of the doctor's staff to observe and/or assist in this procedure for educational purposes.

I also consent to courses of treatment relating to the diagnosis or procedure described herein.

I acknowledge I have read or had this form read and/or explained to me. I fully understand its contents, have been given ample opportunity to ask questions and my questions have been answered satisfactorily. I understand every precaution, consistent with the best medical practice, will be carried out to protect me from adverse reactions to this testing. I give my permission to the staff of Willamette Allergy Center, to proceed with allergy skin testing and to perform necessary procedures and administer necessary medications in treating any adverse reaction that may occur from this testing. All blanks or statements requiring completion were filled in.

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by my doctor and any other physicians or other medical personnel under the direct supervision and control of such physician who may be involved in the course of my treatment.

Patient Name Printed ______________________ Date of Birth ______________

Patient Signature (or Parent Legal Guardian) ______________________ Date Signed ______________

Physician Signature ______________________ Date Signed ______________