Please read this entire form

Allergy Skin Pre-Testing Patient Instructions

You have been scheduled for allergy skin testing on ________________ at _______ , in our office. Please allow 1½ - 2 hrs for the test.

Your follow up appointment with Dr. ____ will be on ____________________ to discuss your test results and treatment plan.

- Please arrive on time to your appointment with your allergy testing packet completely filled out to avoid any cancellations or rescheduling of your appointment.
- Prior to skin testing you must discontinue any allergy medication: antihistamines for 7 days, this includes: Claritin® (Loratadine), Clarinex® (Desloratadine), Allegra® (Fexofenadine), Zyrtec® (Cetirizine), Xyzal® (Levocetirizine), Benadryl® (Diphenhydramine), Astelin/Astepro®, Patanase® and Dymista® nasal sprays.
- You may continue taking your decongestants: Entex La®, Deconsal®, Sudafed®, etc... as well as your nasal steroid sprays: Flonase®, Nasonex®, Veramyst®, Zetonna®, Qnsal® or Omnari®.
- Stay on your inhalers: if you are having trouble breathing the day of the allergy test, the appointment will be rescheduled.
- You will not be tested if you are using a topical steroid on both arms. You may be tested 7 days after the last application.
- No large amounts of Vitamin C (600mg. max.) for a least 7 days prior to the test.
- Eat breakfast or lunch prior to the test and wear a short sleeve shirt.
- If you are taking a sleep aid such as Tylenol® PM, Advil® PM, Unisom®, Sominex®,Compoz® night time sleeping aid, and Unisom® sleep gels maximum strength, they need to be discontinued 3 days prior to the test. They will alter the test results. You may continue taking Ambien® or Lunesta®.
- Herbal supplements that will affect allergy testing include: Licorice, Green Tea, Saw Palmetto, St. Johns Wort, Feverfew, Milk Thistle and Astragalus. Discontinue these 7 days prior to the test.
- If you have a history of asthma, your allergy testing will be performed in two office visits.
- For patient safety, we do not permit children who are not patients in the testing area. Please plan accordingly.

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Allergy Skin Pre-Testing Consent

Patient Name: ______________________________ **Date:** ______________________

Your physician has suggested an allergy skin test be performed in an attempt to identify specific environmental allergens that may be causing you to suffer from persistent allergic rhinitis. All allergens used in testing contain water extracts of pollens, molds, mites, insects or animal dander to which you may possibly have an allergy to. The allergens can be applied by various testing methods which will be determined by your ENT physician.

MQT method: A set of allergens is applied to your forearms using a device that pricks the superficial layer of skin and simultaneously applies a drop of allergen to the site. The prick sites are measured after 20 minutes and then one single injection of each allergen is applied at a strength that is determined by your prick results. This test will take approximately 45 minutes.

IDT method: Sets of allergens of different strengths are individually injected just beneath the superficial skin layer on your upper arms. Each injection site is measured after 15 minutes to determine how you reacted to each allergen in the set. There are 8 allergens in each set and the number of sets that will be injected will be determined by your skin reaction.

Benefits of Allergy Skin Testing:

- Identification of allergens that are causing persistent allergic rhinitis (hay fever) symptoms
- Ability for your physician to develop a more effective treatment plan.

With allergy testing, as with any other procedure that requires substances to be injected into the body, there is the possibility of adverse reactions. These generally are mild and include local reactions or mild systemic reactions. Although rare, more severe systemic reactions are possible. *(See below)*

Local Reactions (commonly):

- Burning or itching at the injection site
- Swelling or hives at the injection site
- Mild pain and tenderness at the injection site

Mild Systemic Reactions (occasionally):

- Nasal congestion and/or runny nose with itching of ears, nose and or throat and/or sneezing occurring within two hours of the injection.
- Itchy, watery or red eyes

Severe Systemic Reactions include (rarely):

- Wheezing, coughing, shortness of breath and or airway swelling
- Generalized hives (welts)
- Swelling of the tissue around the eyes, the tongue, and or throat
- Stomach or uterine (menstrual-type) cramps
- Abnormalities of the heart beat
- Loss of ability to maintain blood pressure and pulse
- Death

Patient Initial ________

We want to assure you that we place great emphasis on patient safety and overall well- being of all those we provide service to and to inform you that we maintain all the necessary equipment, medications and staff who are trained to respond effectively to these types of situations.

Alternatives to Allergy Testing:

- Avoidance
- Medications (antihistamines, nasal steroid spray, others)

I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risk of nontreatment, the procedures to be used, and the risks and hazards involved and I believe that I have sufficient information to give this informed consent. I understand that no warranty or guarantee has been made to me as to result or cure.

I do hereby give consent to be skin tested for allergies. I understand that, although rare, severe systemic reactions may result in permanent disability or even death.

I consent and authorize the treatment of any reactions that may occur as a result of an allergy testing.

Patient Signature: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

Factors Affecting Skin Testing:

By signing below I acknowledge that I was advised by the staff of The Allergy Center during pre-test counseling of any medications I had been taking that may possibly interfere with the test. I further acknowledge that I have not knowingly taken any medications or preparations that contain: Antihistamines, MAO-Inhibitors, Tricyclic Antidepressants, Vitamin C, Herbal Supplements or the drug Strattera (used to treat ADHD) in the past 7 days.

Patient Signature: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

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