PATIENT CONSENT FORM
ALLERGY IMMUNOTHERAPY
(ALLERGY INJECTION THERAPY)

Patient Name: _____

Date: _____

Person Administering Consent: _____

Dr. _____ 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 increases doses of extracts (mixtures) of these allergens. It is considered a common treatment for allergic diseases.

2. I understand that allergy immunotherapy does not take the place of avoidance of allergens to which I am known to be sensitized (allergic) and that the overall effectiveness of this injection treatment program also depends on my complying with recommendations with respect to environmental controls, dietary restrictions, and use of medications.

3. I understand that reduction of allergic sensitivity is the goal of allergen immunotherapy (allergy injection therapy). Improvement is often not seen immediately, and may not be apparent for up to one year. The results are often a reduction, but not complete elimination of symptoms. A few patients may not be helped by immunotherapy at all. I recognize that there is no guarantee that this therapy will, in fact, result in a cure or resolution of my symptoms.

4. I understand that allergy immunotherapy injections are usually given once or twice a week. In special situations (cluster or accelerated allergen immunotherapy), several injections may be given daily. 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.

5. I understand that allergy immunotherapy extracts are prepared under rigidly controlled conditions by trained medical personnel. My allergy extract prescription is prepared according to my specific sensitivities, and is not useable by any other patient. I understand that once the allergy extracts are prepared, I am liable for the expense. Therefore, I recognize that I should contact my insurance company to inquire about medical coverage of the allergy immunotherapy extracts before I sign this consent.

6. I understand that because my child or myself will be receiving injections of substances to which my child or myself is allergic, reactions to the injections may occur. 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. I understand that I should avoid strenuous exercise for two hours after my allergy injection therapy.

7. I understand that allergy injections should be administered in a medical facility. A trained medical person under the supervision of a physician who is immediately available to treat any possible adverse reaction should give these injections. I am required to be observed for a period of at least 30 minutes 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.

8. I understand that if I have any question about whether I should receive immunotherapy, I should discuss this with my physician now or at the time of any injection. 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 evident by decreased peak flows, usually less than 70% of my best peak flow readings (yellow/red zone).

9. I understand that allergy injections cannot be given to patients who are currently taking beta-blocker medications. Examples of beta-blockers include, but are not limited to Inderal, Lopressor, metoprolol, atenolol, Coreg, Toprol, and propanolol. 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. I understand that I will consult my physician if any changes are made in my medication regimen once allergy immunotherapy is initiated.

10. 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.

PATIENT'S CONSENT: I have read and fully understand this consent 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 as to the risks or hazards of the proposed treatment or 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.

_____	_____		
Print Name of Patient	Signature of Patient/Parent/Guardian	Date	Time
_____	_____		
Print Name and Job Title of Witness	Signature of Witness	Date	Time

Facility where injections will be given: _____

_____		
Physician signature	Date	Time