ALLERGY PATIENT INFORMATION PACKET

TESTING FACILITY:

DAWES FAMILY MEDICINE
Tel: 805-934-2488 - Fax: 805-934-2580
Thomas M Dawes, Jr, MD – A Medical Corporation
2342 Professional Parkway, Ste 310, Santa Maria, CA 93455

You will be tested for the most common 70 environmental allergens.

Based on the results, your provider will discuss your treatment plan during a follow up appointment.

The first step is to fill out the attached forms:

- Consent Form for Allergy Scratch Test (Percutaneous Testing)
- New Patient Symptom Survey
- Medications to Avoid 5 -7 days prior to test

Here are the most frequently asked questions.

What should I expect during the test?

Plan on being at the office for about an hour. A clinic staff member will clean your back off with an alcohol pad. When the test is applied to your skin, you will feel slight pressure from the applicator prongs. It will take approximately two minutes to apply the entire test. You will lie face down until the results develop.

How will it feel?

There is slight pressure from the applicators. The test is designed to scratch/prick the first layer of skin. As the test develops, you may experience a temporary itching or a tingling sensation similar to a mosquito bite.

What happens after the test?

After the results are documented, a clinic staff member will wipe off the antigens with alcohol. Immediately the itching sensation will start to subside. If desired, you may be offered an antihistamine and/or an anti-itching cream. The marks from the test may remain visible for up to 48 hours.

How soon will I receive my results?

Your provider will review the results of the allergy test and discuss your results and treatment options at your follow up appointment.

CONSENT FORM FOR PERCUTANEOUS TESTING

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Percutaneous Testing: Allergy skin testing is a clinical procedure that is used to evaluate an immunologic response to environmental allergens. The need for testing and interpretation of test findings must be correlated with signs and symptoms of possible allergies as determined by a complete history and examination of the patient. The number and type of antigens used for testing are chosen judiciously given the patient's symptoms and the tester's clinical judgment. The Test Kit consists of the top 70 allergens in North America. Allergy testing is covered when clinically significant allergic history or symptoms that are not controllable by empiric conservative therapy exists (medication only). For Medicare to cover allergy testing, the following criteria must be met: 1. Testing must correlate specifically to the patient's history and physical findings. 2. The test technique and/or allergens tested must have proven efficacy demonstrated through scientifically valid medical studies published in peer-reviewed literature. 3. Allergy testing must be performed on patients whose environment provides the reasonable probability of exposure to the specific antigen tested. Percutaneous testing is the usual preferred method for allergy testing. Medicare covers percutaneous (scratch, prick or puncture) testing when IgE-mediated reactions occur to any of environmental allergens such as pollen (trees, weeds and grasses), molds, fungi, animals (dog, cat, cattle, horse, mice dander) or insects (cockroach or dust mites).

I give my consent for to have percutaneous testing administered, which has been prescribed by my physician. I acknowledge that an adverse reaction can occur because the test will administer material to which I may be allergic. Although serious reactions are rare, many patients experience an area of local swelling, itching and redness at the site of the prick skin test. This indicates a positive finding. The most severe reaction can involve hives, wheezing, sneezing, itching in the palms of the hands, nose, roof of mouth or throat, or low blood pressure.

Please allow at least 30 to 60 minutes office time for the administration of the percutaneous testing and observation. To avoid a late-cancellation office fee of $100, Dawes Family Medicine requires at least ***24-hour notification to reschedule or cancel the appointment***.

The cost of test varies by health plan, but most health plans cover the test in-network. Please note that insurance deductibles, co-insurance and co-payments may apply. Cash price of the test is $450. ***If the test is not covered by your insurance plan, you will be responsible for the full cost of the test.***

By signing below, you give your consent and acknowledge that you have read the information provided to you and that you fully understand the testing process, possible reactions and office cancellation/financial policy.

Patient Name: _____ Date: _____

Patient or Responsible Party Signature: _____

Printed Name of Responsible Party: _____

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MEDICATIONS TO AVOID

5-7 DAYS BEFORE THE DAY OF YOUR TEST

You have been scheduled for allergy test on _____ at _____.

If you have any questions, concerns or need to reschedule your appointment, please contact the office. To avoid an office fee, you will need to notify the office 24 hours in advance to change your appointment.

Please review the "Medications to Avoid" below and address and questions/concerns with your nurse or provider. The following medications can interfere with your test and force the reaction we are looking for to be suppressed. You must avoid them 5-7 days prior to your test date.

ANTIHISTIAMINES, COUGH, COLD, OR DECONGESTENTS			
Actifed	Chlor-Trimeton	Nolamine	Sleep Aid
Alavert (laratadine)	Clarinex (desloratadine)	Opcon-A (eye drops)	Tavist
Allegra (fexofenadine)	Claritin (loratadine)	Patanol (eye drops)	Trinalin
Astelin	Codimal DH Syrup	Periactin	Tussionex
Atarax	Dimentane Cough Syrup	Phenergen	Tylenol Allergy
Atrohist	Dura-Vent	Rondec	Tylenol Cold
Benadryl (diphenhydramine)	Extendryl	Rynatan	Tylenol Flu
Bromfed	Hycomine Compound	Rynatuss	Vistaril
Brompheniramine	Kronofed	Semprex	Xyzal
Chlorpheniramine	Nolahist	Sinulin	Zyrtec (cetirizine)
NASAL SPRAYS			
Astelin	Aster	Patanase	

Patient may take aspirin, Motrin, or Tylenol, but **DO NOT STOP TAKING BETA BLOCKERS!**

By signing below, I agree to refrain from all medications listed for a minimum of five to seven days prior to the date of my appointment. If test is unable to be completed because I did not discontinue these medications, I understand that I will be responsible for all office fees incurred.

PATIENT SIGNATURE: _____ DATE: _____

Consent for Administration of Sublingual Allergy Immunotherapy

What You Should Know About Sublingual Allergy Immunotherapy

What is the purpose of Sublingual Immunotherapy (SLIT)?
Immunotherapy is a "vaccination" against allergies. However, unlike subcutaneous allergy shots given with a needle, with Sublingual Immunotherapy you take drops of liquid placed under the tongue (not shots) to decrease your sensitivity to allergy causing substances (i.e. animals, pollen, dust mites and mold). This does not mean that immunotherapy is a substitute for avoidance of known allergens or for allergy medication.

Why take allergy immunotherapy?
If you are allergic to one or more environmental substances that you cannot avoid, this is an indication for therapy.

What is the procedure in Sublingual Immunotherapy?
First, your doctor will run a number of tests to pinpoint the substances that cause your allergies. The results of these tests will help your doctor decide whether immunotherapy might help you. Sublingual Immunotherapy begins at very low doses. This dosage is gradually increased on a regular (monthly) basis until a therapeutic dose is reached. The drops will be taken daily to reduce the chances of a reaction and permits the maintenance dose to be reached within a reasonable amount of time.

What can I expect from immunotherapy?
If immunotherapy is successful, you will have fewer reactions and less severe reactions to the substances that cause your allergies to flare up. Allergy drops can improve your quality of life. Your symptoms should be much better if you have followed your doctors dosing instructions. Sublingual Immunotherapy has shown to be safer than allergy injection therapy in many studies and appears to be as clinically effective. The World Health Organization's committee on vaccines stated, "Well designed studies employing high dose sublingual-swallow immunotherapy provide evidence that this form of therapy may be a viable alternative to injection therapy in the treatment of allergic airway disease." It is important to note that allergy vaccines are FDA approved; the sublingual route is considered off label use.

How long will the treatment be?
It usually takes five months to reach a maintenance dose. It usually takes a full year to see significant results. Most patients need two-three years after maintenance for optimal desensitization.

Please contact us if you start any new prescription medications, especially for high blood pressure.

What are possible side effects?
Most patients seem to tolerate Sublingual Immunotherapy without side effects. Rarely, patients have reported local reactions such as an itchy mouth or throat. Even less common are general reactions such as skin rashes, stomach pain or difficulty breathing. If any of the above occurs you should contact your physician immediately.

Females of childbearing potential:
If you become pregnant while on Sublingual Immunotherapy, notify the office staff immediately so that the physician can determine an appropriate dosage schedule. Immunotherapy doses will not be advanced during pregnancy, but may be maintained at a constant level.

PARENTS OF CHILDREN
We ask that you agree to supervise your children's use of the allergy vaccine.

Consent for Immunotherapy (Sublingual Vaccine)

Authorization for Treatment
I have read the information in this consent form and understand it. The opportunity has been provided for me to ask questions regarding the potential risks of immunotherapy, and these questions have been answered to my satisfaction.

I understand that every precaution consistent with the best medical practice will be carried out to protect me from adverse reactions to immunotherapy. I do hereby give consent for the patient designated below to be given immunotherapy over an extended period of time and at specified intervals, as prescribed.

I hereby give authorization and consent for treatment by Thomas M Dawes, Jr, MD and Dawes Family Medicine staff, including authorization and consent for treatment of any reactions that may occur as a result of an immunotherapy.

Your prescription will be sent to a pharmacy that specializes in sublingual immunotherapy preparation. However, you have the right to present and utilize a pharmacy of your choice.

_____
Printed Name of Immunotherapy Patient

_____ _____
Patient Signature (or Legal Guardian) **Date Signed**

I certify that I have counseled this patient and/or authorized legal guardian concerning the information in this Consent for Administration of Sublingual Vaccine and that it appears to me that the signee understands the nature, risks and benefits of the proposed treatment plan.

_____

Physician, PA-C, or NP Signature

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