Chicago Family Asthma & Allergy, SC

Information and Guidelines for the Safe and Effective Administration of Allergy Desensitization Treatment

Please read and follow instructions carefully:

1. Allergen immunotherapy injections, or "allergy shots", consist of dilute samples of allergens, which are the items that cause the patient's allergy symptoms. These are injected subcutaneously according to a carefully devised protocol with the goal to desensitize an allergy patient to their particular allergy cause. Initially, dose strengths increase weekly until a maintenance dose is reached. Then the shot frequency is transitioned to every four weeks, as long as symptoms remain controlled and adverse effects are not observed.

2. Benefits from the desensitization protocol are typically experienced in the first 6-18 months of therapy. Improvement thereafter often continues and may be gradual. Although therapy reduces allergy symptoms for most patients, its efficacy cannot be guaranteed.

3. Optimum therapeutic results usually require three to five years of desensitization therapy. Discontinuation of therapy earlier than this may result in recurrent symptoms. We recommend five years to have the best chance for long-term benefits.

4. Any injection can cause an allergic reaction. These reactions may consist of any or all the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; sneezing; tightness in the throat or chest; coughing; wheezing; shortness of breath; light-headedness; faintness; nausea and vomiting; hives; generalized itching; and anaphylactic shock. Reactions, even though unusual, can be serious and rarely fatal. If this occurs as a result of an allergy injection, it usually begins within thirty minutes of the injection. If one of these reactions occurs, or if you feel that you have become ill as a result of an allergy injection, you must contact one of our doctors or staff immediately.

5. You must wait in our office for 30 minutes after each injection to be observed for symptoms of an allergic reaction.

6. Any injection can cause a reaction of redness or swelling or pain in or on your arm where you receive the injection. If this occurs the day of the injection, it is often a normal reaction and does not require a change in protocol. If it is severe or lasts until the day after the injection, this should be reported to our medical staff prior to your next injection.

7. TO PATIENTS WITH HIGH BLOOD PRESSURE, GLAUCOMA OR HEADACHE OR USING A BETA BLOCKER or ACE INHIBITOR MEDICATION: Please notify our office if a medical practitioner gives you a drug called a *beta blocker or ACE inhibitor*. Using these medications is not an absolute contraindication for use of immunotherapy; but if you have an allergic reaction to immunotherapy, resuscitation medications may not work as effectively.

8. IF YOU STARTED ANY NEW MEDICINE SINCE YOUR LAST VISIT, PLEASE INFORM ONE OF OUR STAFF BEFORE YOUR INJECTION. Please inform your primary physician or practitioner of allergy medication you are taking. You may continue to take your usual allergy and non-allergy medications prior to your injection, unless otherwise advised.

9. If you are feeling well, you may receive your injection(s) without a doctor or practitioner visit. If you are having any symptoms of illness, please talk with our staff or schedule an appointment with a practitioner before receiving an injection.

10. TO OUR FEMALE PATIENTS: Not all drugs used in treatment of allergic diseases have been cleared for use during pregnancy. If you are planning on becoming pregnant, or if you are pregnant, please discuss drug use and allergy immunotherapy dosing with one of our practitioners.

11. If you have any questions regarding your injections or your allergy symptoms, please call our office at any time.

12. Every ten (10) months, a new supply of allergy extract vials will be prepared. Unless you notify us of the desire to stop receiving allergy injections, these will be renewed every ten (10) months. Allergy shot vial serum may expire if you do not keep with the regular schedule, leading to additional charges for serum replacement. At a minimum, you will need to schedule an office visit with a practitioner ONCE EACH YEAR to review your progress and allergy control.

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ALLERGEN IMMUNOTHERAPY PATIENT CONSENT FORM

Allergen immunotherapy, also known as allergy injections or shots, should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any or all the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; wheezing; light-headedness; faintness; nausea and vomiting; hives; generalized itching; shortness of breath; and anaphylactic shock. Reactions, even though infrequent, can be serious and rarely fatal. You are required to wait in the medical facility in which you receive the injections for 30 minutes after each injection. If the patient is 17 years of age or younger, a parent or legal guardian must be present during the waiting period.

I verify that I am (or the patient is) not taking a beta blocker or ACE inhibitor medication, or if one is being used, that I have discussed with the physician the risks/benefits of doing so during immunotherapy (see information sheet).

I have read and understand the patient information regarding immunotherapy. The opportunity has been provided for me to ask questions regarding the potential side effects 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 against such reactions. I also agree that if I have an allergic reaction to the injections that the physician-in-charge has permission to treat said reaction.

I acknowledge with my signature that I am authorizing the office to bill my account for allergen vaccines, even if, for any reason, I decide not to initiate or to continue allergen immunotherapy after the vaccine has been made. I agree to obtain prior authorization, if needed, from my insurance plan. I further understand that the final responsibility for the payment of these charges is mine, with or without insurance coverage. I also understand that unexpected reactions or interruptions in my injection schedule may result in the delay of my schedule and lead to the expiration of certain vials before they are used completely, requiring them to be remixed with additional charges added to my account. With this knowledge, I request the vials be ordered and prepared for me.

Patient Name: _____ Date of Birth: _____ Date:_____

Patient Signature: _____

Parent/Guardian Signature (print name/relationship): _____ Date:_____

As parent or legal guardian, I understand that I must accompany my child throughout the entire 30-minute wait. _____ initial