CERTIFIED ALLERGY & ASTHMA CONSULTANTS
Scott L. Osur, MD • Janet L. Claassen, MD • Thomas N. Flaim, MD • Michael G. Katlan, MD
Kris K. Saririan, MD • Ari Kounavis, MD • Kemp Bundy, MD, MBA • Manisha Relan, MD
Phone (518) 434-1446
Fax (518) 434-0806

VENOM IMMUNOTHERAPY CONSENT

_____ _____
Patient's Name Record No.

I have discussed the need for venom injections with Dr. _____ at our office visit as a treatment for my allergic condition. I received a patient education brochure describing venom immunotherapy which is made part of this consent by reference. Alternate forms of treatment including stinging insect avoidance and emergency treatment with epinephrine were also discussed.

The potential side effects caused by venom injections have been explained to me. I understand that they include, but are not limited to, localized swelling at the injection site and the possibility of a systemic reaction. A systemic reaction can vary from minor symptoms (itchy throat or eyes, runny nose, sneezing) to a more severe reaction (wheezing, chest tightness, hives, difficulty swallowing). Although rare, patients may have more severe reactions, including drop in blood pressure, shock and even death.

I understand to maximize the benefit from venom injections and minimize the risk of side effects, injections MUST be administered in a physician's office when a Physician, Physician's Assistant or Nurse Practitioner is on the premises. As most severe reactions to venom injections occur within the first 30 minutes after receiving an injection, I understand I must wait in the office at least 30 minutes following an injection. I will report any generalized or systemic reactions immediately to the physician, even if this occurs after leaving the office, so that appropriate treatments to relieve the reaction may be given. While treatment for a reaction that occurs during the waiting period is administered in the office, a severe reaction may require transport to an emergency room for further treatment. The monitoring of prolonged or delayed symptoms may also necessitate transfer to an emergency room.

I acknowledge that **[____ I am not] / [____ I am]** presently taking a beta-blocker medication. I understand that these medications are commonly used to treat high blood pressure, arrhythmias, heart palpitations, tremors, glaucoma and migraine headaches. They may increase my risk for a systemic reaction that is resistant to treatment. If I am not currently taking a beta blocker medication, I agree to notify the physicians of this office if such a medication is prescribed to me.

I acknowledge that **[____ I am not] / [____ I am]** presently taking an ACE inhibitor medication. I understand that these medications are commonly used to treat high blood pressure, congestive heart failure, diabetes and for renal protection. They may increase my risk for a systemic reaction that is resistant to treatment. If I am not currently taking an ACE inhibitor medication, I agree to notify the physicians of this office if such a medication is prescribed to me.

In signing this consent, I acknowledge that I have read and understand the above information, the additional risk factors that may be present as detailed on the back, and the contents of the patient education brochure, and that my physician has satisfactorily answered my questions. I also authorize Certified Allergy & Asthma Consultants to prepare the appropriate allergenic extracts to be used for my (my child's) injection therapy. I understand that I may be responsible for payment of fees incurred for the preparation of materials that are not covered by my insurance.

_____ _____
Patient's (Parent/Guardian) signature Date

See reverse side for additional risk factors and minor consent, if applicable.

Additional Consent – Other Medical Conditions

Allergen Immunotherapy has a risk of allergic reactions as detailed on the previous page. Patients with certain medical conditions may be at greater risk of complications as a result of reactions from immunotherapy injections and/or treatment provided to treat these reactions if they were to occur.

Additional risks apply to me in receiving injections because of the presence of the following medical condition(s).

( ) Autoimmune conditions

Rheumatologic conditions, lupus, psoriasis, multiple sclerosis and others may be exacerbated as a result of allergen immunotherapy.

( ) Heart conditions

The presence of heart disease, irregular heart rhythm, and others carry greater risk of heart events including: sudden irregular rhythm, poor oxygen delivery, heart attack and cardiac arrest with resultant low blood pressure, low oxygen level and severe respiratory compromise from severe allergic reactions. Treatment with epinephrine used to reverse allergic reactions may also result in heart compromise, irregular rhythm, and poor outcome.

( ) Seizure disorder

Patients with seizure disorder are at risk of acute seizure events with drop in blood pressure and low oxygen level which may result from a severe allergic reaction. The combination of severe allergic reaction and acute seizure event can lead to greater risk of poor outcome from these reactions if they were to occur.

( ) Psychiatric conditions and Physical challenges

Patients with certain psychiatric conditions and physical challenges unable to communicate are at risk of delayed recognition of allergic reaction. This can lead to more severe reactions and complications if these reactions were to occur.

( ) Other _____

Additional Consent for minors age 16 and over, if applicable.

As parent (guardian) of _____ I acknowledge that he/she is at least 16 years of age. I hereby consent to him/her receiving allergy injections at Certified Allergy & Asthma Consultants unaccompanied by a parent or guardian. Further, I authorize treatment as deemed necessary including the administration of medications to alleviate systemic reactions, without the presence of a parent or guardian. This consent shall remain valid until revoked by me in writing.

_____ _____

Patient's (Parent/Guardian) signature Date