Revere Health Allergy & Immunology

Henry Yeates, MD • Tammy Jacobs, MD

(Office Only) MRN: _____

PATIENT NAME: _____

DOB: ___/___/_____ **AGE:** _____ **SEX: M / F**

DATE: ____/____/_____

SUBCUTANEOUS IMMUNOTHERAPY (SCIT, ALLERGY SHOTS) CONSENT FORM AND SAFETY GUIDELINES

RISKS

I understand that among the risks of subcutaneous immunotherapy are immediate reactions, delayed reactions, severe allergic reactions, and other reactions. I also understand that, as with every treatment, there is a possibility of unexpected complications.

The following specific risks were discussed with me:
IMMEDIATE REACTIONS: The risks of immediate allergic reactions include: large local reactions involving itching and swelling (most commonly); but also includes generalized itching, rash, hives, swelling of the lips, tongue, or throat, chest pain, chest tightness, shortness of breath, wheezing, abdominal pain, nausea, vomiting, diarrhea, palpitations, dizziness, confusion, anaphylaxis, shock, and death.

DELAYED REACTIONS: The risks of delayed allergic reactions include: large local reactions involving itching and swelling (most commonly); but also includes generalized rash and itching. Unusual reactions may include liver or kidney involvement, fevers, chills, joint pains, and ulcerations.

SAFETY GUIDELINES

For all patients starting or on allergen immunotherapy injections, please note the following guidelines to reduce the risk of serious and life-threatening allergic reactions.

1. **You will need to receive injections twice a week when possible, with at least 24 hours and preferably two days between injections. No more than two injections a week.**
2. **Do not exercise for one hour before and two hours after your injection.**
3. **We recommend waiting 20 minutes after your injection before leaving the doctor's office.**
4. **Take an antihistamine (i.e. Zyrtec/cetirizine, Allegra/fexofenadine, Claritin/loratadine) at least 1 hour prior to receiving your allergy injection. If antihistamines make you drowsy, you can take your antihistamine the night before your injection.**
5. **Do not get an injection if you are sick, have a fever, cold, chest congestion, wheezing, or any symptoms of asthma or severe allergies.**
6. **If the shot patient is under the age of 14, a parent or guardian must be present at the time of the injection.**
7. **Tell the nurse immediately:**
    a. **If after an injection you experience any generalized symptoms (such as hives, hay fever, coughing, asthma, dizziness, flushed face).**
    b. **If you are pregnant. Although allergy injections may be continued at maintenance dose while a person is pregnant, the dose cannot be increased during pregnancy. Please make an appointment with Dr. Yeates or Dr. Jacobs if you become pregnant while receiving allergy injections.**

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8. **If you experience a delayed shot reaction after you leave the doctor's office, report the reaction in detail, along with any treatment you received, at your next injection.**

9. **Your injection schedule will be modified or the frequency of your injections can be increased for reasons including but not limited to:**
    a. **Starting new vials**
    b. **Missed injections due to vacation, illness, or other reasons.**
    c. **Large local or systemic reactions**
    d. **A change in extract formula**

10. **To receive maximum benefits allergy shots should be taken all year round for 3-5 years. The effectiveness of these injections is diminished and your cost increases when the injection schedule is interrupted. Extracts expire one year after they are made. When new extracts or dilutions are required, the usual and customary fees will apply.**

11. **It is important that you give complete and accurate medical information to the doctor and staff giving the injections— failure to do so can have serious, even life-threatening consequences.**

12. **FOR YOUR SAFETY: In the unlikely chance that you have a reaction, you may be treated in a neighboring Urgent Care facility or physician with subsequent charges from that physician or department. If the reaction is severe or life-threatening, you may be transported to the nearest Emergency Department with subsequent charges from that department.**

Patient Attestation: I have had an opportunity to read, discuss and understand regarding the risks and benefits of this procedure and of the alternatives with my physician. I have had an opportunity to review and ask questions regarding the above guidelines to minimize risk of serious and life-threatening reactions. All my questions have been answered to my satisfaction, and I consent to this treatment.

_____ Date _____ Time _____

Patient Signature (patient or guardian)

Relation to patient: _____ (or circle) self