Chestnut Hill Allergy & Asthma Associates, LLC

Immunotherapy Consent Form

Immunotherapy, hyposensitization, or allergy injections 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 of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the last under extreme conditions. Reactions, even though unusual, 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. Rapid Desensitization Immunotherapy (Cluster) patients are required to wait in the office 60 minutes after last dose.** 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 (or patient) am not taking beta blocker medications. If I am, I have discussed the risks/benefits of doing so with my physician (see information sheet).

I have read (new patient) or re-read (established patient) and understand the patient information sheet on immunotherapy. The opportunity has been provided for me to ask questions regarding 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, the physician-in-charge has permission to treat said reaction.

I agree that I will schedule an appointment to see the doctor every six months. I will also obtain prior authorization (insurance referral) if needed, from my primary care physician as per insurance plan indicates.

Print Patient Name:_____ Patient DOB:_____

Signature of Patient:_____ Date:_____

You always have the option to receive immunotherapy at CHAA if you so choose, however if you plan to receive allergy injections at a remote location, please complete the following:

Medical Facility/Practice Name:_____

Facility Address:_____

Facility Phone Number:_____

Staff Witness:_____ Date:_____