Allergy & Asthma Center
of Southern Oregon, PC
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IMMUNOTHERAPY CONSENT FORM

Dr. Kerwin/Dr. Parks/Dr. Israelsen has recommended Immunotherapy (allergy shots) as a form of treatment for you or your child. It is important for you to understand the purpose and expectations of allergy shots, the general program (schedule), the risks of allergy shots and alternate treatment options.

The purpose of Immunotherapy is to make the patient less sensitive to one or more specific allergens (pollens, dust mites, molds, animals, bee venom, etc.). Immunotherapy is often considered if allergic symptoms are not controlled by other measures, if medications are causing side effects or if your symptoms require prolonged use of medication.

An extract is prepared according to a patient's specific sensitivities and may be given only to that individual patient. Injections are given at weekly or bi-weekly intervals in gradually increasing doses. When the highest dose (maintenance dose) is reached the shots may be gradually lengthened to a monthly schedule. It usually takes 5-8 months to reach maintenance dose. The total duration of Immunotherapy is usually 3-5 years.

The reduction in sensitivity is not seen immediately and often takes a year to be apparent. The majority (80% or more) of patients note significant, but not complete reduction, in allergic symptoms and still need to keep exposure to allergens as low as possible and may need to take medications. In this circumstance, medicines tend to be more effective than before Immunotherapy and are needed for shorter periods of time. A smaller percentage note nearly complete control of allergy symptoms with Immunotherapy. A small percentage find Immunotherapy does not change their symptoms appreciable and the injections are stopped if this is the case. Your probability of improvement can often be estimated by your history and allergy evaluation. We consider the role of Immunotherapy in the treatment of allergic disease to be an adjunct not a substitute for other measures such as allergen avoidance and medications.

It is possible to have a systemic reaction to allergy shots. These usually occur within minutes after an injection (but may rarely occur up to several hours later) and are easily treated, but require immediate attention. The reactions may involve itching, rash or swelling in places other than the injection site, hay fever symptoms, trouble breathing, and faintness due to dropping blood pressure. These reactions are very rare and usually reverse quickly if treated, but have the potential of being serious and even fatal. Therefore, you must receive allergy injections in a physicians office. You must wait the designated time period after your injection (usually 20-30 minutes) and you should notify the nurse if you notice any of the above symptoms.

You should not receive your allergy injection if you have a fever. You should notify the nurse if you are having a flare-up of asthma or hives. You should avoid strenuous exercise for two hours after your shot. You should notify us of all new medications you are taking. You cannot take allergy shots if you are taking BETA BLOCKER medications (used for blood pressure and heart problems, migraines or as an eye drop for glaucoma).

Local reactions are common after allergy shots and consist of redness, swelling and itching. These may be immediate or delayed in onset and may last hours to a day or more. If local reactions are excessive report the reaction to the shot nurse before your next injection.

Allergy shots may be given in pregnancy. Please notify us if you are pregnant as minor changes in your shot program may be needed and we should review your overall allergy management program.

Please notify us if any questions or concerns arise during the course of your Immunotherapy program.

Check box if applicable:

☐ I understand that getting allergy shots while on Beta Blockers could moderately increase the risks of allergy shots or make treatment of shot reactions more difficult, but I would still like to try allergy shots, while continuing my Beta Blocker.
Pt. Initial: _________ Date:_______________

I, the undersigned, have read the above information and wish to proceed with allergy Immunotherapy treatment. I understand that by signing this form that I am giving my permission for the antigens to be mixed and billed to my insurance. I also understand that I am responsible for payment of the extracts once this form is signed.

I have read and understand this statement: Pt. Initial ________ Date _______________ Staff Initial__________

______________________	______________________	___________	___________
(Patient Name Printed)	**(Parent or Legal Guardian Name)**	**(Patient DOB)**	**(Patient ID#)**

______________________	___________
(Patient/Parent or Legal Guardian Signature)	**(Today's Date)**

______________________	______________________	___________
(Witness Name Printed)	**(Witness Signature)**	**(Today's Date)**