Allergy Patient Information Packet

Welcome to Allergy Testing day!

Today you will be tested for the most common 70 environmental allergens and 8 foods. The test will take about two minutes to apply to your back using plastic applicators. You will know what you are allergic to in just 15 minutes. Based on the results, your doctor will discuss your treatment plan before you leave the office.

The first step is to fill out the attached forms:

- Consent Form for Allergy Scratch Test
- New Patient Symptom Survey

Here are the most frequently asked questions.

What should I expect during the test?
A clinic staff member will clean your back off with an alcohol pad. When the test is applied to your skin, you will feel slight pressure from the applicator prongs. It will take approximately two minutes to apply the entire test. You will lie face down until while the results develop.

How will it feel?
There is slight pressure from the applicators. The test is designed to scratch/prick the first layer of skin. As the test develops, you may experience a temporary itching or a tingling sensation similar to a mosquito bite.

What happens after the test?
After the results are documented, a clinic staff member will wipe off the antigens with alcohol. Immediately the itching sensation will start to subside. If desired, you may be offered an antihistamine and/or an anti-itching cream. The marks from the test may remain visible for up to 48 hours.

How soon will I receive my results?
Your provider will review the results of the allergy test and discuss your treatment options before you leave the office.

Now it's time for your test. You are on your way to learning your allergy triggers!

Consent Form for Percutaneous Testing

By signing below, I give my consent for ____ (patient) to have percutaneous testing administered, which has been prescribed by my physician. I acknowledge that an adverse reaction can occur because the test will administer material to which I may be allergic. Although serious reactions are rare, many patients experience an area of local swelling, itching and redness at the site of the prick skin test. This indicates a positive finding. The most severe reaction can involve hives, wheezing, sneezing, itching in the palms of the hands, nose, roof of mouth or throat, or low blood pressure.

It is extremely important that you allow 20 to 30 minutes for the administration of the percutaneous testing and observation. If you cannot wait, you must reschedule your appointment.

By signing below, you give your consent and acknowledge that you have read the information provided to you and that you fully understand the testing process and possible reactions.

Patient Name: ____ Date: __________________

Patient or Responsible Party Signature: ____

Allergy Tech Name: ____

Allergy Tech Signature____

Percutaneous Testing: Allergy skin testing is a clinical procedure that is used to evaluate an immunologic response to environmental allergens. The need for testing and interpretation of test findings must be correlated with signs and symptoms of possible allergies as determined by a complete history and examination of the patient. The number and type of antigens used for testing are chosen judiciously given the patient's symptoms and the tester's clinical judgment. The Test Kit consists of the top 70 allergens in North America.

Allergy testing is covered when clinically significant allergic history or symptoms that are not controllable by empiric conservative therapy exists (medication only).

For Medicare to cover allergy testing, the following criteria must be met:

1. Testing must correlate specifically to the patient's history and physical findings.

2. The test technique and/or allergens tested must have proven efficacy demonstrated through scientifically valid medical studies published in peer-reviewed literature.

3. Allergy testing must be performed on patients whose environment provides the reasonable probability of exposure to the specific antigen tested.

Percutaneous testing is the usual preferred method for allergy testing. Medicare covers percutaneous (scratch, prick or puncture) testing when IgE-mediated reactions occur to any of environmental allergens such as pollen (trees, weeds and grasses), molds, fungi, animals (dog, cat, cattle, horse, mice dander) or insects (cockroach or dust mites).

New Patient Symptom Survey

Patient Name: ____ Date of Birth: __________

COMMON SYMPTOMS: Circle the number according to severity: 0 = NONE, 1 = MILD, 5 = VERY SEVERE

Symptom							Symptom						
Abdominal Gas or Cramping	0	1	2	3	4	5	Hives	0	1	2	3	4	5
Arthritis or muscle pain	0	1	2	3	4	5	Hyperactivity	0	1	2	3	4	5
Asthma	0	1	2	3	4	5	Itching	0	1	2	3	4	5
Cough	0	1	2	3	4	5	Nasal Congestion	0	1	2	3	4	5
Eczema	0	1	2	3	4	5	Poor memory or concentration	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5	Sneezing	0	1	2	3	4	5
Frequent colds or sore throat	0	1	2	3	4	5	Trouble breathing while sleeping	0	1	2	3	4	5
Frequent sinus or ear infection	0	1	2	3	4	5	Watery, red, itchy eyes	0	1	2	3	4	5
Headache	0	1	2	3	4	5	Wheezing	0	1	2	3	4	5

SYMPTOM SCORE: ________ List any other current symptoms: ______________________

HISTORY

Are there any foods that cause you any problems? ____________________ How? ______________

Do you have a history of allergies? ( ) Yes ( ) No If yes, how long have you had allergies? ______________

What season(s) do your allergies usually flair up? ( ) Spring ( ) Summer ( ) Fall ( ) Winter ( ) All Year

Have you been allergy tested before? ( ) Yes ( ) No If yes, when______________________________

Does any medication give you relief of your allergy symptoms? ( ) Yes ( ) No Comment:______________

Do you have pets at home? ( ) Yes ( ) No Type: __________________ Do they cause symptoms? ________

Are you exposed to fumes or dust? ( ) Yes ( ) No Comment: ______________________

Do you smoke? ( ) Yes ( ) No How much? ________________

Are you exposed to smoke in your environment? ( ) Yes ( ) No

Who else in your family has allergies/asthma? ( ) Mom ( ) Dad ( ) Sibling ( ) Children

Have you been diagnosed with asthma? ( ) Yes ( ) No If so when? ________ Severity: ( ) Mild ( ) Moderate ( ) High

Do you think your asthma is under control? ( ) Yes ( ) No

How often are you using your inhaler? ______________________________

Are you taking any sleep aids? ____________

CONTRAINDICATIONS

Do you suffer from uncontrolled asthma or reduced lung function? ( ) Yes ( ) No

Ever had a severe allergic reaction? ( ) Yes ( ) No Ever hospitalized due to allergies? ( ) Yes ( ) No

Taking Beta Blockers to treat heart disease: ( ) Yes ( ) No Name of Medication: ______________

Have you taken any allergy, antihistamine or cold medicine in the past 72 hours? ( ) Yes ( ) No

Are you pregnant? ( ) Yes ( ) NO ( ) N/A

CLINICAL USE ONLY

Is Patient Recommended for Allergy Test? ( ) Yes ( ) No Date of Allergy Test__________ Skin ( ) Blood ( )

Refer Patient to a specialist ( ) Yes ( ) No

Reviewed by: ____________________ Provider: ____________________ Date:________

Patient Schedule Form

You have been rescheduled for allergy testing on ________________ at _____________.
If you have any questions, concerns, or need to reschedule your appointment, please contact the office.

Please review the 'Medications to Avoid' below and address any questions/concerns with your nurse or provider. The following medications can interfere with your test and force the reaction we are looking for to be suppressed.

Please Avoid These Medications for 5 to 7 Days Before The Day of Your Test

Antihistamines, Cough, Cold, or Decongestants:

Actifed	Chlor-Trimeton	Nolamine	Sleep Aid
Alavert (loratadine)	Clarinex (desloratadine)	Opcon-A (eye drops)	Tavist
Allegra (fexofenadine)	Claritin (loratadine)	Patanol (eye drops)	Trinalin
Astelin	Codimal DH Syrup	Periactin	Tussionex
Atarax	Dimetane Cough Syrup	Phenergan	Tylenol Allergy
Atrohist	Dura-Vent	Rondec	Tylenol Cold
Benadryl (diphenhydramine)	Extendryl	Rynatan	Tylenol Flu
Bromfed	Hycomine Compound	Rynatuss	Vistaril
Brompheniramine	Kronofed	Semprex	Xyzal
Chlorpheniramine	Nolahist	Sinulin	Zyrtec (cetirizine)

Nasal Sprays:

Astelin	Aster	Patanase

Patient may take aspirin, Motrin or Tylenol, but DO NOT STOP TAKING BETA BLOCKERS!

Patient Signature ____
(By signing above, I agree to refrain from all medications listed for a minimum of five to seven days).

Medela Rememdium Solutions/LLC Patient Services
1829 W. Drake #101
Tempe, Arizona 85283
1-866-889-5489

Consent for Administration of Sublingual Allergy Immunotherapy

What You Should Know About Sublingual Allergy Immunotherapy

What is the purpose of Sublingual Immunotherapy (SLIT)?
Immunotherapy is a "vaccination" against allergies. However, unlike subcutaneous allergy shots given with a needle, with Sublingual Immunotherapy you take drops of liquid placed under the tongue (not shots) to decrease your sensitivity to allergy causing substances (i.e. animals, pollen, dust mites and mold). This does not mean that immunotherapy is a substitute for avoidance of known allergens or for allergy medication.

Why take allergy immunotherapy?
If you are allergic to one or more environmental substances that you cannot avoid, this is an indication for therapy.

What is the procedure in Sublingual Immunotherapy?
First, your doctor will run a number of tests to pinpoint the substances that cause your allergies. The results of these tests will help your doctor decide whether immunotherapy might help you. Sublingual Immunotherapy begins at very low doses. This dosage is gradually increased on a regular (monthly) basis until a therapeutic dose is reached. The drops will be taken daily to reduce the chances of a reaction and permits the maintenance dose to be reached within a reasonable amount of time.

What can I expect from immunotherapy?
If immunotherapy is successful, you will have fewer reactions and less severe reactions to the substances that cause your allergies to flare up. Allergy drops can improve your quality of life. Your symptoms should be much better if you have followed your doctors dosing instructions. Sublingual Immunotherapy has shown to be safer than allergy injection therapy in many studies and appears to be as clinically effective. The World Health Organization's committee on vaccines stated, "Well designed studies employing high dose sublingual-swallow immunotherapy provide evidence that this form of therapy may be a viable alternative to injection therapy in the treatment of allergic airway disease." It is important to note that allergy vaccines are FDA approved; the sublingual route is considered off label use.

How long will the treatment be?
It usually takes five months to reach a maintenance dose. It usually takes a full year to see significant results. Most patients need two-three years after maintenance for optimal desensitization.

What are possible side effects?
Most patients seem to tolerate Sublingual Immunotherapy without side effects. Rarely, patients have reported local reactions such as an itchy mouth or throat. Even less common are general reactions such as skin rashes, stomach pain or difficulty breathing. If any of the above occurs you should contact your physician immediately.

Females of childbearing potential:
If you become pregnant while on Sublingual Immunotherapy, notify the office staff immediately so that the physician can determine an appropriate dosage schedule. Immunotherapy doses will not be advanced during pregnancy, but may be maintained at a constant level.

Please contact us if you start any new prescription medications, especially for high blood pressure.

PARENTS OF CHILDREN
We ask that you agree to supervise your children's use of the allergy vaccine.

Medela Rememdium Solutions/LLC Patient Services
1829 W. Drake #101
Tempe, Arizona 85283
1-866-889-5489

Consent for Immunotherapy (Sublingual Vaccine)
Authorization for Treatment

I have read the information in this consent form and understand it. The opportunity has been provided for me to ask questions regarding the potential risks 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 from adverse reactions to immunotherapy. I do hereby give consent for the patient designated below to be given immunotherapy over an extended period of time and at specified intervals, as prescribed. I hereby give authorization and consent for treatment by ______________________________ (physician) and staff, including authorization and consent for treatment of any reactions that may occur as a result of an immunotherapy. Your prescription will be sent to a pharmacy that specializes in sublingual immunotherapy preparation. However, you have the right to present and utilize a pharmacy of your choice.

____
Printed Name of Immunotherapy Patient

______________________________ ______________________________
Patient Signature (or Legal Guardian) Date Signed

I certify that I have counseled this patient and/or authorized legal guardian concerning the information in this Consent for Administration of Sublingual Vaccine and that it appears to me that the signee understands the nature, risks and benefits of the proposed treatment plan.

______________________________ ____________________
Physician Signature Date Signed

Environmental/Food Combo Test Kit Panel

PATIENT NAME: ______________________________

PATIENT ID______________________________

TESTING DATE:_____/_____/_____

Insurance:______________________________

Preauthorized: Yes [ ] No [ ]
Taking Antihistamines: Yes [ ] No [ ]

Testing Rescheduled: Yes [ ] No [ ] Date Test:______________

History of Asthma: Yes [ ] No [ ]
Spirometry Requested: Yes [ ] No [ ]
Spirometry Performed: Yes [ ] No [ ]
Skin Testing Consent Signed: Yes [ ] No [ ]
Immunotherapy Consent Signed: Yes [ ] No [ ]

Billable Procedures:

[ ] 95004 - Skin Test x 80 Units

Upper Respiratory:
- ( ) J20.9 Acute Bronchitis
- ( ) R05 Cough Extrinsic
- ( ) J45.998 Asthma Extrinsic or Unspecified
- ( ) J11.0 Influenza URI Acute
- ( ) J17 Pneumonia
- ( ) J45.90 Asthma, Unspecified
- ( ) J06.9 URI w/ Multiple Sites
- ( ) R06.2 Wheezing

Ear:
- ( ) H66.90 Otitis Media, Unspecified
- ( ) H65.00 Serous Otitis Media Acute
- ( ) H65.20 Serous Otitis Media Chronic

Eye:
- ( ) H10.3 Acute Atopic Conjunctivitis
- ( ) H10.45 Chronic Atopic Conjunctivitis

GI:
- ( ) K52.2 Allergic Gastroenteritis (Food)
- ( ) K90.0 Celiac
- ( ) R11.10 Vomiting, Unspecified

Skin
- ( ) L20.89 Atopic Dermatitis
- ( ) L25.9 Contact Dermatitis
- ( ) L27.2 Dermatitis, Food
- ( ) L27.0 Dermatitis, Medication
- ( ) L22 Diaper Dermatitis
- ( ) L25.5 Plant Contact
- ( ) L50.0 Urticaria/Angioedema Allergic
- ( ) L50.8 Urticaria, Unspecified

Allergic Rhinitis:
- ( ) J31.0 Chronic Rhinitis
- ( ) J30.1 Rhinitis due to pollen (Hay fever)
- ( ) J30.81 Rhinitis due to animal dander
- ( ) J33.0 Nasal Polyps
- ( ) J34.3 Hypertrophy of Nasal Turbinates

Sinus:
- ( ) J32.0 Chronic Sinusitis
- ( ) J01.9 Acute Unspecified Sinusitis
- ( ) J32.9 Chronic Unspecified Sinusitis
- ( ) R09.82 Post Nasal Drip

PANEL A: CONTROLS & GRASS POLLENS			PANEL B: WEED POLLENS 1			PANEL C: WEED POLLENS 2		
A1	+ CONTROL, HISTAMINE		B1	ALFALFA POLLEN		C1	PIGWEED, ROUGH	
A2	- CONTROL, GLYCERINE		B2	BAYBERRY (WAX MYRTLE)		C2	RAGWEED, GIANT (TALL)	
A3	BAHIA GRASS		B3	COCKLEBUR		C3	RAGWEED, FALSE	
A4	BERMUDA GRASS		B4	ENGLISH PLANTAIN		C4	RAGWEED, SHORT	
A5	JOHNSON GRASS		B5	KOCHIA (FIREBUSH)		C5	RAGWEED, WESTERN	
A6	KENTUCKY BLUE/JUNE GRASS		B6	LAMBS QUARTER		C6	RUSSIAN THISTLE	
A7	PERENNIAL RYE GRASS		B7	MARSHELDER, ROUGH		C7	SHEEP SORREL	
A8	TIMOTHY GRASS		B8	MUGWORT, COMMON		C8	SAGEBRUSH, COMMON	
PANEL D: TREE POLLENS 1			PANEL E: TREE POLLENS 2			PANEL F: TREE POLLENS 3		
D1	ALDER, WHITE		E1	CYPRESS, BALD		F1	OAK, WHITE	
D2	ASH, WHITE		E2	ELM, AMERICAN		F2	OLIVE TREE	
D3	BIRCH, WHITE		E3	ELM, CHINESE		F3	PALM, QUEEN	
D4	BIRCH, RED RIVER		E4	HICKORY, SHAGBARK		F4	PECAN TREE POLLEN	
D5	BOX ELDER		E5	JUNIPER WESTERN		F5	PINE WHITE	
D6	CEDAR, RED		E6	MAPLE, SUGAR POLLEN		F6	PINE AUSTRALIAN	
D7	CEDAR, MOUNTAIN		E7	MULBERRY RED		F7	POPLAR, WHITE	
D8	COTTONWOOD, EASTERN		E8	OAK, LIVE VIRGINIA		F8	PRIVET	
PANEL G: TREES, MOLDS & FUNGI			PANEL H: MOLDS & FUNGI 2			PANEL I: ANIMALS & INSECTS		
G1	SYCAMORE, AMERICAN		H1	CURVULARIA (Bipolaris)		I1	CAT HAIR	
G2	WALNUT, BLACK POLLEN		H2	DRESCHLERA (HEMINTH)		I2	CATTLE EPITHELIUM	
G3	WILLOW, BLACK		H3	EPICOCCUM NIGRUM		I3	COCKROACH MIX	
G4	ALTERNARIA TENIUS		H4	FUSARIUM		I4	DOG EPITHELIUM	
G5	ASPERGILLUS MIXED (M)		H5	MUCOR		I5	HORSE EPITHELIUM	
G6	CANDIDA ALBICANS		H6	PENICILLIUM, NOTATUM (F)		I6	MITE FARINAE	
G7	CEPHALOSPORIUM, ACREM.		H7	PHOMA HERBARUM		I7	MITE PTERONY	
G8	CLADOSPORIUM, (F)		H8	PULLULARIA, AUREOBASIDIUM		I8	MOUSE EPITHELIUM	

PANEL J: FOOD			PANEL J: FOOD			PANEL J: FOOD		
J1	BAKERS YEAST		J4	COW MILK		J7	SOYBEAN	
J2	BARLEY		J5	EGG WHITE		J8	WHOLE WHEAT	
J3	CORN		J6	RICE				

TestKit Results Guide:

11mm+: Extremely High Allergy **9mm:** Very High Allergy **7mm:** High Allergy **5mm:** Moderate Allergy **4mm:** Low Allergy **<4mm: Trace Allergy**