IMMUNOTHERAPY CONSENT FORM

Patient Name: _____ DOB: _____ MRN: _____

PCP: _____ Allergist: _____ Office of Injection: _____

I have been advised and understand the following information and expectations of me by my allergist regarding allergy immunotherapy (allergy shots) at Pediatrics Northwest P.S. or authorizing provider.

1. This therapy is expected to last approximately 3-5 years after reaching the maintenance dose.
    a. I will need to schedule follow-up appointments with my allergist at least every 3-6 months for the first year, then yearly thereafter.
2. The recommended schedule for most immunotherapy is twice weekly until I reach the maintenance vial (approximately 3 months), then I will need to come in weekly. The injection frequency may be adjusted by the allergist based on response to therapy.
3. There is always a risk involved when I receive allergy immunotherapy, this may include pain, redness, and swelling at the injection site. There is a risk of cough, wheeze, hives, or anaphylaxis, which is a severe allergic reaction. **I agree to pretreat with an oral antihistamine, or other designated medication per the allergist, 1-2 hours prior to every injection appointment (Example: Zyrtec, Claritin).**
4. I will advise the "allergy nurse" of any previous reactions or current symptoms I am having prior to my injection.
5. There will be a parent or guardian present at each visit if a minor (i.e., less than 18 years of age) is getting injections. Another adult may accompany the minor only if PNW has written consent.
6. I will remain in the allergy office or waiting area for 30 minutes after each injection and **must** be checked by the allergy nurse before leaving.
7. I will immediately make appropriate personnel aware of any concerns such as itching, cough, wheezing, hives, or other symptoms thought to occur because of the allergy injections.
8. I will complete the Asthma Control Test (ACT) screening tool prior to each injection.
9. I understand that by signing this form, the Immunotherapy process will begin. My allergy serum will be mixed, and Pediatrics Northwest will bill the insurance on file.
10. **I am financially responsible for all charges, whether covered by insurance.** I understand that Pediatrics Northwest will bill my insurance but will not accept responsibility for collecting claims or negotiating disputed claims. **I understand that I am responsible for all non-covered services.**

Parent/Guardian Printed Name: _____ Date: ____/____/____

Patient/Guardian Signature: _____

Witness Signature: _____ Date: ____/____/____