ALLERGY TESTING CONSENT FORM

Patient Name: _____ Date of Birth: _____

SKIN TESTS. Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction, which consists of a wheal, swelling, or flare in the surrounding area of redness. The results are read at 15 to 20 minutes after the application of the allergen. The skin test methods are:

a) Prick Method - The skin is pricked with a needle where a drop of allergen has already been placed.
b) Intradermal Method - This method consists of injecting small amounts of an allergen into the superficial layers of the skin.

Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

ALLERGENS. You will be tested to important airborne allergens and possibly some foods. These include trees, grasses, weeds, molds, dust mites, animal danders, and possibly some foods. The skin testing generally takes 45 minutes.

Prick (also known as percutaneous) tests are usually performed on your back but may also be performed on your arms. Intradermal skin tests may be performed if the prick skin tests are negative and are performed on your arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes and, typically, no treatment is necessary for this itchiness.

Occasionally, local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next week or so. They should be measured and reported to your physician at your next visit. You may be scheduled for skin testing to antibiotics, caines, venoms, or other biological agents. The same guidelines apply

REACTIONS. Skin testing will be administered at _____ with a medical physician or other health care professional 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; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances.

Please let the physician and nurse know if you are pregnant or taking beta-blockers. Allergy skin testing may be postponed until after the pregnancy in the unlikely event of reactions to the allergy testing, and beta-blockers are medications that may make the treatment of the reaction to skin testing more difficult.

Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.

After skin testing, you will consult with your physician or other health care professional who will make further recommendations regarding your treatment.

We request that you do not bring small children with you when you are scheduled for skin testing unless they are accompanied by another adult who can sit with them in the reception room.

I acknowledge that I have read this consent form and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. Alternatives to the skin tests have also been fully explained to me. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

Patient Signature: _____ Date: _____

Print Name: _____

Parent/Guardian Signature:* _____ Date: _____

Print Name: _____

Witness Signature: _____ Date: _____

Print Name: _____

*As parent or legal guardian, I understand that I must accompany my child throughout the entire procedure and visit.