Advancements in Allergy and Asthma Care, Ltd.

Michael R. Wexler, MD | Micah L. Karasov, DO
Pam McNallan, PA-C | Molly Love, PA-C | Kristin Larson, PA-C | Beth Voigt, CNP
12450 Wayzata Blvd | Suite 215 | Minnetonka, MN | 55305
Phone: 952-546-6866 | Fax: 952-512-0038

CONSENT FOR ALLERGY INJECTION(S) (IMMUNOTHERAPY)

1. Allergy injections have been recommended as a treatment option for your allergy symptoms. The treatment program is a series of injections consisting of pollens, dust components, molds, and/or animals depending on your individual allergies. They are generally administered weekly, beginning with a weak solution and then increased in concentration and amount until maintenance levels are reached in approximately 6 months, at which time the injections are given 1 to 2 times per month. This level is maintained approximately 4 to 5 years. The treatment program will be reviewed in 3 months, and at least once yearly thereafter, to evaluate progress. (If patients are receiving the injections at a different location, the program will be reviewed every 3 months for the first year).

2. **SPECIAL INSTRUCTIONS**

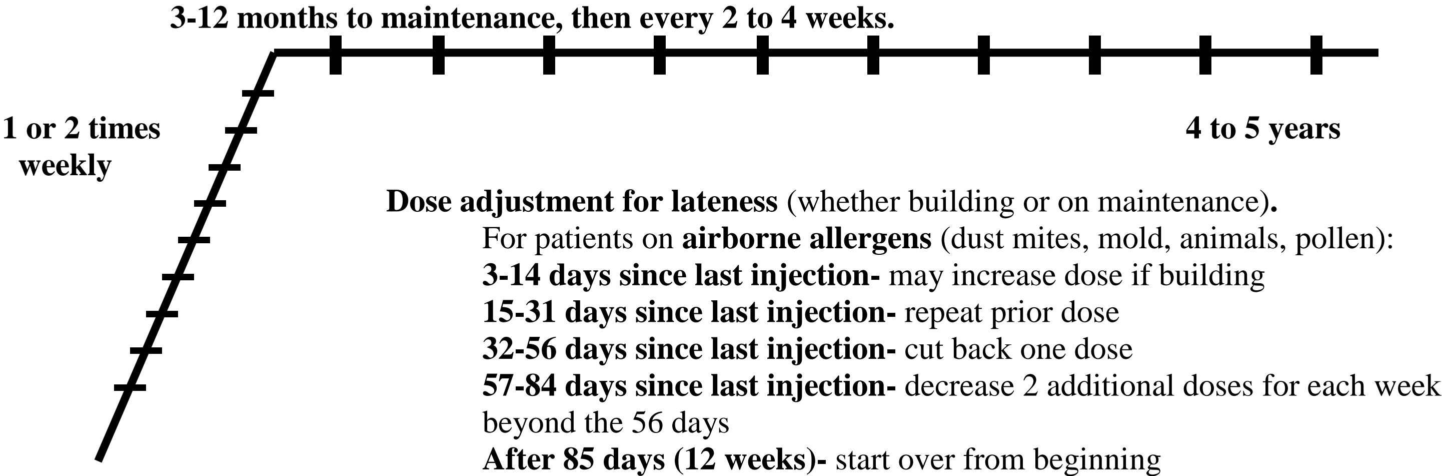
   No vigorous exercise for approximately 1 hour before and 2 hours after injections.

   Bring epinephrine auto-injector to clinic and carry on day of injections.

   Please tell us about problems encountered with previous injections.

   You must wait in the office at least 30 minutes after receiving your injections.

3. If patient is late, it may effect the program. For example, if at maintenance level and more than 32 days have passed with no injection, the next injection dose will need to decrease. If more than 85 days have passed with no injection, patient needs to be seen and will need to restart from the beginning of the program.



Dose adjustment for lateness (whether building or on maintenance)**.**
For patients on **airborne allergens** (dust mites, mold, animals, pollen):
3-14 days since last injection- may increase dose if building
15-31 days since last injection- repeat prior dose
32-56 days since last injection- cut back one dose
57-84 days since last injection- decrease 2 additional doses for each week beyond the 56 days
After 85 days (12 weeks)- start over from beginning

4. **REACTIONS**
   Reactions, though not expected, may occur after any injection. Usually this would occur within 30 minutes so it is imperative that you wait in the clinic each time. Some swelling and redness at the injection site is normal. An ice pack will lessen the swelling. Large amounts of swelling greater than a quarter or redness lasting greater than 24 hours should be reported to the nurses. If symptoms of tightness in the throat or chest, coughing, wheezing, lightheadedness, faintness, nausea, stomach cramping, hives or generalized itching after leaving the clinic, use epinephrine auto-injector and call 911. If experiencing mild symptoms such as sneezing, itchy eyes or runny nose, take an antihistamine and call Advancements in Allergy and Asthma Care, Ltd. (952-546-6866) or go to the emergency room. Very rare instances of death from allergy injections are reported.

***OUR OFFICE MUST BE INFORMED OF ALL REACTIONS OTHER THAN SMALL LOCAL REACTIONS AT THE SITE OF INJECTION.**

5. **ALLERGY INJECTIONS SHOULD NOT BE GIVEN IF:**
   Your allergies or asthma are not well controlled or you are experiencing a flare.
   You have a fever or other illness.
   You are unable to wait 30 minutes after injections. Failure to remain in the clinic for the allotted time following allergy shots is inconsistent with your provider's advice and releases the clinic of any legal responsibility.
   You have had or will have certain immunizations (like measles) within 48 hours of your allergy injections.
   You are on a beta blocker medication. Beta blockers treat high blood pressure, migraines, and heart conditions. Please notify the nurses or allergist if you are taking these medications.

*Dosage adjustments may be made during pregnancy. Please notify us if you are pregnant.

6. **Prepared extracts have <u>expiration dates ranging between 3-12 months</u>. Please plan to start as soon as your extracts are ready.**

Immunotherapy Treatment Consent

I understand the information above and was informed of the potential risks and possible alternative methods of treatment. I hereby authorize Advancements in Allergy and Asthma Care, Ltd. to prepare my immunotherapy program(s), administer my immunotherapy (allergy shots) and, if necessary, provide additional medications in the event of a potential adverse shot reaction.

By signing, you agree to start immunotherapy treatment and be billed for allergy extracts at the time our clinic mixes your extract(s). Payment for allergy extracts will remain your responsibility should you cancel your immunotherapy treatment.

________________________________ ________________________________
Patient (or Parent/Guardian) signature (Date)

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(Printed name of parent/guardian)

________________________________ ________________________________
(Provider) (Nurse)

(Label)