INFORMED CONSENT FOR ALLERGY TESTING AND TREATMENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS.

PATIENT’S NAME: ______________________________________________________       DATE: _________________

In addition to the requirements of Georgia law, the following consent is also intended to improve communication with and education of patients. The following has been explained:

1. The DIAGNOSIS requiring this procedure: ALLERGIC RHINITIS.

2. The NATURE of this procedure is: HYPOSENSITIZATION. (trying to make you less sensitive to what you are allergic to). The procedure may also include Testing of the Skin for allergic reactions with a skin prick device and/or drawing blood for RAST blood testing.

3. The PURPOSE of these procedures is: TO TEST FOR ALLERGY AND HELP RELIEVE ALLERGIC SYMPTOMS.

4. POSSIBLE RISKS: It is impossible to truly list all of the complications that may occur from any procedure. However, risks here have been carefully considered. There may be possible risks involved in these procedures including, but not limited to:
   - Local reactions – Burning, itching, bleeding, swelling and/or hives, redness of skin, skin blistering/sloughing, and/or possible infection at the injection/puncture site
   - Mild systemic reactions: nasal congestions and/or “runny nose”; skin rash; diarrhea; headache; Itching of ears, nose, throat and/or sneezing occurring within two hours of the injection/puncture and/or itchy, watery or red eyes.
   - More severe reactions: Wheezing, coughing, or shortness of breath; bronchial asthma; generalized hives (welts); swelling of tissue around the eyes, tongue or throat; stomach or uterine (menstrual-type) cramps, possible miscarriage (if pregnant).
   - Rare complications: Abnormalities of the heart beat; delayed response; Loss of ability to maintain blood pressure and pulse; Anaphylactic shock; Death.
   - Severe: There is the possibility of severe reaction involving the heart, lungs and blood vessels which, if unrecognized and untreated, could be FATAL.

5. PRECAUTIONS to be taken: Experience has shown that the majority of reactions from allergy testing and/or immunotherapy which require emergency treatment occur within 20 minutes of an injection/puncture. It is for this reason that all patients who receive allergy injections must remain for 20 minutes in our designated waiting area until checked by one of our allergy nurses. If you choose to leave prior to the 20 minute waiting time after your injection, you do so against medical advice and therefore accept all responsibility and liability for any subsequent reaction(s) from your allergy shot(s). Occasionally, a reaction will occur after a patient who received their injection(s) or skin testing leaves our allergy office. It is vitally important that any such reaction be reported to the allergy nurse or physician before receiving the next injection. If you are ever concerned about a reaction you have after leaving our office, you should return to our office or go to your local emergency room or immediate care facility for treatment.

IF YOU ARE HAVING A LIFE-THREATENING EMERGENCY CALL 911!
6. DURATION OF TREATMENT: The average patient will be on allergy immunotherapy, whether shots or drops, for three to five years and maybe more. This schedule is impossible to predict and will differ from patient to patient depending on what your allergies are, how severe they are, and how you tolerate treatment. Your treatment with immunotherapy will be more successful and pose less risk if you consistently receive your shots according to your shot schedule, which will be communicated to you by the allergy department.

NOTE: If you are not consistent in arriving at the appointed time(s) for your allergy shots, you not only lessen the success of your treatment but also increase your risk of having adverse reaction(s) to your immunotherapy, including the risk of anaphylactic shock. If you cannot be consistent in arriving at the appointed time(s) for your allergy shots, you will be asked, for your own protection, to consider alternative forms of allergy treatment. A repeat offender who is unable to stick to their injection schedule may be prevented from receiving allergy shots and their treatment may be discontinued at the discretion of the physician and/or the allergy department.

7. The LIKELIHOOD OF SUCCESS of these procedures is excellent.

8. The PRACTICAL ALTERNATIVES to these procedures include antihistamines and other medical treatments.

9. PROGNOSIS: If the patient chooses not to have the above procedures, the patient’s prognosis (future medical condition) is unknown.

I understand that the physician, medical personnel or other assistant will rely on statements about the patient, the patient’s medical history, and other information in determining whether to perform the procedures or the course of treatment for the patient’s condition in recommending the procedures, which has been explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of these procedures.

I understand that during the course of the procedures described above it may be necessary or appropriate to perform additional procedures, which are unforeseen, or not known to be needed at the time this consent is given. I consent to and authorize the person described herein to make the decision concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

I consent to the presence of observers in the allergy room for medical, scientific or educational purposes approved by my physician.

I consent to the taking and publication of any photographs or video tapes taken during the course of the patient’s operation or procedure for medical, scientific or education purposes approved by my physician.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS, AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN, AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING, BUT NOT LIMITED TO, THE MATERIALS LISTED BELOW, RELATED TO THE PROCEDURE DESCRIBED HEREIN. Additional materials used include: Sheets #A-1, A-3, A-4, A-5, A-6, A-7, and A-11.

I am aware that taking beta-blockers can greatly increase the risk of severe reactions, asthma and possible death while taking allergy shots, drops, or skin tests. I agree to inform the allergy department at any time that a physician places me on a beta-blocker.
I voluntarily consent to allow Ear, Nose and Throat of Northwest Georgia or any physician designated or selected by Drs. Morgan, Walker and Howard, and all medical personnel under the direct supervision and control of such physicians and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

Please answer the following questions by circling yes or no:

1. Have you read the above document? YES NO

2. Do you understand the nature, expected benefits, and risks of the above described testing/treatment procedures as well as alternative treatment options? YES NO

3. Are you satisfied that all your questions have been answered? YES NO

4. Do you understand that there are no guarantees to the testing and/or treatment outcomes? YES NO

5. Do you understand that a parent or guardian must be present in order for a patient under the age of 18 to receive consultation and/or testing and/or treatment of any kind? YES NO

6. If RAST blood testing is preferred over skin/prick testing, do you consent to have your blood drawn today so that we may send your blood off for laboratory testing? YES NO

7. Do you understand that all patients who receive injections must remain for 20 minutes after their injection(s) until checked by an allergy nurse and that anyone leaving prior to this time does so against medical advice and thus accepts all liability for subsequent reaction(s)? YES NO

8. Do you understand that if you have any reaction(s) to your allergy injections or to the skin prick testing procedure, you are responsible for reporting these reactions in a timely manner to our allergy department and, that if you are concerned about reaction(s), you will either return to the office allergy department or go to the local emergency room or immediate care facility for treatment? YES NO

9. Do you understand that if you are unable to consistently arrive for injections according to your shot schedule, this increases your risk of having an adverse reaction to immunotherapy? YES NO

10. Do you understand that if you fail to consistently arrive for injections according to your shot schedule, our office may discontinue your immunotherapy treatment, for your own safety? YES NO

I, the undersigned, have read all three (3) pages of this form in its entirety and/or have had this form explained to me and fully understand the contents of this authorization.

Patient: ___________________________________________________ Date: __________________________

___________________________________________             _______________________________________
Person giving consent                                               Relationship to patient, if not the Patient

Patient is unable to sign because of _____________________________________________________________

I consent to have a medication vial prepared for me by the allergy technician(s) at ENT of NWGA upon receipt of my lab results and/or skin prick test results so that a vial test may be performed at my next visit and so that I may begin my immunotherapy as soon as possible. If allergy drops are chosen instead of allergy shots for my immunotherapy, I consent to have the drops ordered according to my test results.

Patient: ___________________________________________________ Date: _________________________

_______________________________________________                 _________________________________________
Person giving consent                                                         Relationship to patient, if not the Patient

Patient is unable to sign because of _____________________________________________________________

ENT of NWGA Staff Witness to the signing of this document: __________________________
Date: __________________________

A-2 08/26/2008