Fairfax Pediatric Associates

ALLERGY TESTING

PATIENT INFORMATION SHEET

Please read the following information about allergy testing in detail and ask the provider if you have any questions. The testing procedure consists of an allergy assessment followed by skin prick testing. Allergy assessment consists of a history of your child's symptoms, medical history, medication use, diet, and environmental factors followed by examination.

Skin prick testing is a method of testing for allergic antibodies. When the test is performed, a small superficial break is made in the skin with needle through a drop of each item to be tested. Pricks are usually performed on your child's back or on your child's forearms.

If your child has 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 child's skin within 15 to 20 minutes.

The size of the reactions will be measured. After this time if the reaction continues to irritate your child, a topical anti-itch cream can be applied. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. After the test, your child can participate in any form of activity

Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

Skin prick testing is a low risk procedure when performed in a doctor's office. The risk of an adverse reaction is expected to be less than 1%. Skin testing will be administered at this medical facility with a medical physician or other health care professional present since occasional reactions may require immediate therapy.

Reactions may consist of any 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 rarely shock or anaphylaxis. If your child has a history of fainting, please let the provider or other staff member know so necessary precautions can be taken when administering the test.

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.

TO PREPARE FOR TESTING DAY — MEDICATIONS TO AVOID:

1. Your child must stop prescription or over the counter oral antihistamines **5 days prior to scheduled skin testing.** These include cold tablets, sinus tablets, hay fever medications, or oral treatments for itchy skin at the site of testing, over the counter allergy medications, such as Claritin, Zyrtec, Allegra, Xyzal, Alavert, Actifed, Dimetapp, Benadryl, and many others. If you have any questions whether or not your child is using an antihistamine, please ask the nurse or the doctor.

2. Your child should discontinue nasal and eye antihistamine medications, such as Patanase, Pataday, Astepro, Optivar, Dymista, Zaditor, Visine A, or Astelin at least **2 days prior to the testing.**

3. Medications such as over the counter sleeping medications (e.g. Tylenol PM) and other prescribed drugs, such as amytriptyline hydrochloride (Elavil), hydroxyzine (Atarax), doxepin (Sinequan), and imipramine (Tofranil) have antihistaminic activity and should be discontinued at least 2 weeks prior to receiving skin test after consultation with your physician who prescribed those medications. Please make the doctor or nurse aware of the fact that your child is taking these medications so that you may be advised as to how long prior to testing your child should stop taking them.

MEDICATIONS THAT YOUR CHILD CAN CONTINUE:

1. Your child may continue to use intranasal steroid sprays such as Flonase, Rhinocort, Nasonex, Nasacort, Omnaris, Veramyst and Flonase Sensimist. Your child may also use nasal saline.

2. Your child may continue using asthma inhalers (such as Albuterol, Xopenex, Pulmicort, Dulera, QVAR, Advair, Flovent, budesonide) or leukotriene antagonists (e.g. Singulair); however, if your child is having an asthma attack or exacerbation, allergy testing should not be performed at this time.

3. Most drugs do not interfere with skin testing; however, it is important that your provider and nurse know about every drug your child is taking (bring a list if necessary).

Allergy Testing Informed Consent and Financial Waiver

NAME: _____ **DOB:** _____

I authorize the providers and clinical staff of Fairfax Pediatric Associates to perform skin prick and intradermal skin testing on my child for the detection of possible allergies. I understand that I must accompany my child throughout the entire procedure and visit.

I further consent to the performance of such other or additional procedures different from that now contemplated, whether or not arising from presently foreseen conditions, which the above named providers or their assistants may consider necessary or advisable in the course of the procedure. I have been made aware of certain risks and complications that are associated with the allergy testing procedure and allergy treatment. These include, but are not limited to hypotensive episodes (drop in blood pressure), worsening of allergic symptoms (runny nose, itchy eyes, hives) and in rare cases, anaphylactic reaction (severe allergic reaction) including possible death.

I have read the patient information sheet on allergy skin testing 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. I understand that every precaution consistent with the best medical practice will be carried out to protect my child against such reactions. I understand that if immediate life-threatening events happen during the procedure, my child will be treated accordingly.

I understand that the result/outcome of the treatment/procedure cannot be guaranteed. This document has been fully explained to me and I certify that I understand its contents and agree with the above. By signing below, I state that I have the legal authority to consent for this patient.

_____ _____

Parent/Guardian Printed Name and Signature Date

Financial Waiver:

I understand that my health care insurance benefits may not cover the cost of the services provided by or recommended by my physician/provider. In the event that my insurance company declines to reimburse Fairfax Pediatric Associates, PC, for non-covered services, I agree to assume the full financial responsibility for any portion not covered including any portion applied toward my deductible or coinsurance amount. Allergy Skin Testing ($12.00 per allergen).

_____ _____

Parent/Guardian Printed Name and Signature Date