ALLERGY SKIN TESTING INSTRUCTIONS AND CONSENT FORM

PREPARING FOR OCULAR ALLERGY TESTING

1. Review and below information and instructions on how to prepare for testing.
2. Review and stop medications, if applicable, as instructed on last 2 pages of “Medications to Avoid Prior to Allergy testing".
3. Depending on your plan, Ocular Allergy Testing is covered by most major insurances. A copay/remaining balance after insurance has paid will be patient's responsibility. If you would like to know the exact amount that you will be paying, please call your insurance to find out the specifics on how much of the testing they cover and use procedure code/CPT code 95004.

DO NOT

1. No prescription or over the counter oral antihistamines should be used 5 days prior to scheduled skin testing. These include cold tablets, sinus tablets, hay fever medications, or oral treatments for itchy skin, over the counter allergy medications, such as Claritin, Zyrtec, Allegra, Actifed, Dimetapp, Benedryl, and many others. Prescription antihistamines such as Clarinex and Xyzol should also be stopped at least 5 days prior to testing. If you have any questions whether or not you are using an antihistamine, please ask the nurse or the doctor. In some instances, a longer period off these medications may be necessary.
2. You should discontinue your nasal and eye antihistamine medications, such as Patanase, Pataday, Astepro, Optivar, or Astelin at least 2 days before the testing. In some instances, a longer period off these medications may be necessary. If you have any questions regarding the use of an antihistamine, please ask the nurse or the doctor.
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. Please make the doctor or nurse aware of the fact that you are taking these medications so that you may be advised as to how long prior to testing you should stop taking them.

YOU MAY

1. You may continue to use your intranasal allergy sprays such as Flonase Rhinocort, Nasonex, Nasacort, Omnaris, Veramyst and Nasarel.
2. Asthma inhalers (inhaled steroids and bronchodilators), leukotriene antagonist s (e.g.Singulair, Accolate) and oral theophylline (Theo-Dur,T-Phyl, Uniphyl, Theo-24, etc.) do not interfere with skin testing and should be used as prescribed.
3. Most drugs do not interfere with skin testing but make certain that your physician and nurse know about every drug you are taking including Over-the-Counters. (Please provide the doctor with a current list).

Skin testing will be administered at this facility under the supervision of your physician or other health care professional 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 a reaction 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 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 me against such reactions.

_____ _____/_____/_____
Patient Name Printed Date of Birth

_____ _____/_____/_____
Patient Signature Today's Date

_____ _____/_____/_____
Parent or legal guardian* Today's Date

**as a parent or legal guardian of the above named patient, I understand that I must accompany my child throughout the entire procedure and visit.*

_____ _____/_____/_____
Witness Signature Today's Date