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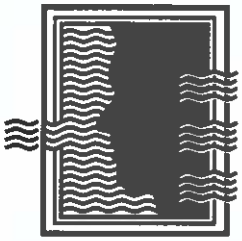
Kim Scott, F.N.P., A.E.-C, CORLN
Alexis L. Buettner, MPA, PA-C



EASTERN VIRGINIA
EAR, NOSE & THROAT
SPECIALISTS

Administrator - Melanie Hoy
Audiology - Paula A. Abraham, Au.D., CCC-A
Stephanie R. Howard, M.A., CCC-A
Stephanie M. Collins, Au.D., CCC-A
Michael W. Lemay, Au.D., CCC-A

ALLERGEN IMMUNOTHERAPY PATIENT CONSENT FORM

Patient Name: _____ Account# _____ Date: _____

Immunotherapy allergy injections should be administered at a medical facility with trained medical staff present since occasional reactions may require immediate treatment. These reactions may consist of any or all the following symptoms:

Itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and anaphylactic shock, the last under extreme conditions. Reactions, even though unusual, can be serious and rarely, fatal.

I understand that I am required to **wait for at least 20 minutes** in the medical facility after injections are administered. I understand that children under the age of 18 are required to have a parent or legal guardian present during the entire 20 minute waiting period after administration of injections.

I verify that I am not taking **Beta Blocker** medications or that if I am, I have discussed the risks/benefits of doing so with my physician and he/she has approved that the beta blocker be held 24 hours prior to receiving allergy injections. I understand that E.V.E.N.T.S must have a signed consent from my physician before I receive injections.

I understand that immunotherapy should NOT be initiated during **Pregnancy**. If pregnancy occurs during the build-up phase of immunotherapy, the dose must be held. If the patient is receiving a dose unlikely to be therapeutic, discontinuation of immunotherapy will be considered. I understand that if I am receiving allergen immunotherapy maintenance doses, I may continue at the same dose during pregnancy if it has been approved by my Obstetrician.

I understand that exercise is discouraged 2 hours before and after receiving allergy injections. The American Academy of Otolaryngic Allergy studies have shown an increased risk of exercise induced anaphylaxis.

I have read and understand the Allergen Immunotherapy Patient Consent form. The opportunity has been provided for me to ask questions regarding the potential side effects of immunotherapy 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. I also agree that if I have an allergic reaction to the injections that the physician-in-charge has permission to treat the reaction.

My signature authorizes the office to bill for the allergy serum at the time of my injection. I understand that if, for any reason, I decide not to initiate the allergen immunotherapy program after the serum has been made, I am responsible in full for the cost of the serum. Allergy serum may be prepared up to 1 week prior to my appointment. Therefore any cancellations must be reported prior to the serum being made. I agree to obtain a prior authorization/referral, if needed, from my insurance plan prior to my scheduled appointment.

PATIENT_____ DATE _____

PARENT or LEGAL GUARDIAN_____ DATE _____

WITNESS_____ DATE: _____