Delaware Otolaryngology Consultants LLC
Dr Beth R Duncan MD
17316 Coastal Hwy Suite 1
Lewes DE 19958
Office 302-644-2232 Fax 302-644-2237

ALLERGY TESTING

APPOINTMENT DATE _____/_____/_____ at _____:_____ AM/PM for testing.

Follow up with Dr Duncan Date _____/_____/_____ at _____:_____ AM/PM.

1) You may call your insurance company to check on coverage for allergy testing. Most insurance companies **do** cover allergy testing. Ask if the following CPT codes (billing codes) are covered: 95004 - MQT prick tests x 24 units 95024 - Intradermal testing x 22 units These codes are the tests we do and if they are not covered by your insurance, you will have to pay out of pocket for them. If they are not covered, contact your doctor and ask what other types of testing can be done.The treatment code is 95117 with dx code J30.89. The mixing code is 95165. Some insurance companies may require a referral. Please ask your insurance company if one is needed and if so, ask your primary care doctor to give you a referral.

2) MEDICATIONS: It is very important that you read the attached list of medications that need to be stopped and or avoided before testing can be done. If you do take a medication that interferes with allergy testing, please call to discuss or reschedule your testing appointment. Always make sure the office has an updated list of medications on file.

3) CLOTHING: Please wear either a comfortable T-shirt or tank top. Testing is done on both arms up to the shoulders, both lower and upper.

4) FOOD/DRINK/TOBACCO: There are no restrictions on what you eat however you would need to **refrain from Caffeine and Nicotine the day of testing**. You are welcome to bring something to drink into the test with you if you would like.

5) PERFUME/COLOGNE/BODY LOTION: Please do not wear any on the day of testing. Deodorant is fine.

6) The allergy testing appointment will take roughly 60 minutes. You will then follow up with your doctor as scheduled.

Please make other arrangements for children, as we are not able to accommodate them during testing.

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Consent to Allergy Evaluation, Testing, and Treatment

1) I _____ authorize the performance of allergy evaluation, testing, and treatment to begin on Date _____/_____/_____ Time _____:_____ under the care of Beth Duncan MD.
2) I consent to:
    A. The Testing Procedures and Treatment
    B. Such Procedures and treatment in addition to or different from those now contemplated whether or not arising from presently unforeseen conditions, which the above named doctor or her associates or assistants may consider necessary or advisable in the course of testing and treatment procedures.
    C. The administration of such medications may be considered necessary or advisable by the doctor or associates or assistants responsible for this service.
    D. The admittance of observers to the room for the purpose of advancing medical education.

3) I have been explained the nature of the testing procedures, alternate methods of treatment, the risks involved with treatment, and the possibilities of complications such as: localized swelling, irritation, and itching at the injection site. The patient may also experience an increase in his/her allergy symptoms, generalized (whole body) hives and swelling, difficulty breathing, anaphylactic shock and possible death. **No guarantee or assurance has been given by anyone as to the results that may be obtained.**

4) I certify that I have read and fully understand the above consent to allergy testing and treatment thereof, that the explanations therein referred to were made, that all blanks or statements requiring insertion or completion was filled in and the inapplicable paragraphs, if any, were stricken before signed.

Signature of Patient / Parent (Guardian) _____

The Foregoing consent was read,discussed, and signed in my presence, and in my opinion the person so signing did so freely with full knowledge and understanding.

Signature of Witness_____**Date** _____/_____/_____

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Allergy Department / Immunotherapy
Policies, Procedures & Financial Responsibility

In our office we offer two different options for treatment of your allergies.

The first treatment option is Allergy Shots, which is usually covered by insurance. However, depending on your insurance you may be subject to a copay, coinsurance, or deductible for your shots/mixing of serum. Allergy shots are given in our office by a RN or Medical Assistant weekly.

The second treatment option is with Sublingual Drops, which are **not covered by insurance**. This therapy consists of drops that are given under the tongue daily. These drops consist of allergy extracts selected based on your allergy testing results. You would come into our office for an appointment once a month to receive a new bottle. You will be taking the first dose of each new bottle in our office, then continuing the bottle at home as directed. The monthly cost of **Sublingual Drops is $100.00 for 1 bottle**. The beginning phase is 4 months therefore you are responsible for the first 4 bottles which is $400.00. Every mixing thereafter is mixed with 2 bottles ($200). **I understand that if I decide not to initiate or continue treatment after the bottles have been made, I am still responsible for the cost of the bottle(s) made in advance.**

Anytime you come to our office for your allergy treatment, please bring your EpiPen with you (if you have one). We also follow the guidelines of the American Academy of Allergy, Asthma and Immunology which states that you shall remain in the office for 20 minutes after receiving your immunotherapy. If you cannot wait the 20 minutes or if you leave the office prior to the 20 minute time frame and are not examined by a medical professional before leaving, you are then leaving against medical advice.

Please sign and date below stating that you have read and understand the policies and procedures of the Allergy Department, as well as my financial responsibility for any costs not covered by my insurance.

Patient Name:_____ DOB _____/_____/_____

Patient / Guarantor Signature:_____ Date _____/_____/_____

Witness Signature:_____ Date _____/_____/_____

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To ensure accurate testing results, certain medicines should be stopped prior to testing, although you should not stop medicines without talking to your prescribing physician.

Medications that interfere with testing include but are not limited to:

Antihistamines * are medicines used to treat allergies, nausea, and dizziness. Many are found in over the counter cold medicines. Please discontinue them as follows:

• **14 Days Prior**	**Prednisone / Medrol**

• **Stop 5 Days Prior**	• **Stop Nasal Sprays 5 Days Prior**
Allegra (fexofenadine) Atarax (hydroxyzine) Clarinex (desloratadine) Claritin (loratadine) Periactin (cyproheptadine) Xyzal (levocetirizine) Zyrtec (ceteririzine)	Astelin (azelastine) Astepro (azelastine) Dymista (azelastine/fluticasone) Patanase (olopatadine)

• **Stop 5 Days Prior**	• **Stop 5 Days Prior**
ANY over the counter allergy/cold medicine All PM medications containing Diphenhydramine (Benadryl) or chlorpheniramine (Chlor-Trimeton)	Allergy eye drops: (Prescription or over the counter)

• **Stop Herbal Supplements 5 Days Prior**	
Feverfew Green Tea Licorice	Saw Palmetto St John's Wort

Beta blockers are commonly used for blood pressure and heart conditions. Should you get a severe reaction to the allergy skin testing, the antidote we administer would be ineffective. We need you off of them for 7 days prior to testing. For your safety, you may not receive allergy testing or immunotherapy (allergy shots) if you are taking this type of medication.

DO NOT STOP YOUR ASTHMA MEDICATIONS!

Albuterol (ProAir), Accolate (zafirlukast) and Zyflo (zileuton), Nasal sprays not listed above, Sudafed, and expectorants like Mucinex can also be continued.

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Adverse Reactions

Serious reactions are rare but could be life threatening which is why we require you to stay for 20 minutes after treatment. Most reactions occur within 15 minutes - we are prepared, you are not. The following are indications of a serious reaction:

- ❖ Itching on the palm of the hands
- ❖ Swelling of the face, hands, and/or throat
- ❖ Difficulty with breathing
- ❖ Numbness of lips
- ❖ Generalized Hives
- ❖ Tightness in Chest
- ❖ Wheezing
- ❖ Nausea
- ❖ Dizziness
- ❖ Feeling of great anxiety

If you experience any of the above symptoms outside of our office:

1. Take Benadryl and Use your EpiPen (if you have one)
2. Call 911 and/or go to the nearest Emergency Room
3. Alert our office Immediately

A Small itchy red bump at the site of the injection is common and not worrisome. Reactions that are important to tell us about are those that occur at a location different from where the shot was given.

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EMERGENCY MEDICATION KIT

Your Emergency Medications will be called into your pharmacy prior to testing/treatment.

1) **EpiPen** (Epinephrine Auto Injector): This should be carried around with you at all times and only used for Severe Systemic Reactions. Some reactions include:Mouth,throat,skin:itching,swellng,tightness,hives ; Gut:vomiting,diarrhea, cramps ; Lungs: Shortness of breath, cough, wheezing ; Heart: weak pulse, dizziness, low blood pressure

2) **Medrol Dose Pack**: This prednisone pack will be called in for Mild Reactions that occur outside of our office under the physicians directions.

3) **Benadryl, Benadry Cream, Hydrocortisone Cream**: You should have this at home for Mild reactions (these are all over the counter)

I fully understand these Medications will be used only in the event of an emergency as described by the allergy techs and/or physician.

Patient Name _____ DOB ____/____/____

Patient/Guardian Signature _____Date ____/____/____

EpiPen OPT OUT/REFUSAL

I do not want to have the EpiPen called in for me even though it is going against medical advice per our office policy/procedure to do so. I understand that while in the office they have what is needed for an anaphylactic reaction however once I leave the office I will not have that available to me. If a reaction occurs you must call 911 Immediately for emergency care.

Patient/Guardian Signature_____Date ____/____/____

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Sino-Nasal Outcome Test (SNOT-20) Date ____/____/____

Patient Name _____ DOB ____/____/____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate you answering the following questions to the best of your ability.There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

Considering how severe the problem is when you experience it, and how frequently it happens. Please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using the scale:

0=No Problem 1=Mild or Slight 2=Very Mild 3=Moderate
4=Severe 5=As Bad as can be

1. Need to blow nose	0 1 2 3 4 5	O
2. Sneezing	0 1 2 3 4 5	O
3. Runny Nose	0 1 2 3 4 5	O
4. Post Nasal discharge	0 1 2 3 4 5	O
5. Cough	0 1 2 3 4 5	O
6. Thick Nasal Discharge	0 1 2 3 4 5	O
7. Ear Fullness	0 1 2 3 4 5	O
8. Dizziness	0 1 2 3 4 5	O
9. Ear Pain	0 1 2 3 4 5	O
10. Facial Pain/Pressure	0 1 2 3 4 5	O
11. Difficulty falling asleep	0 1 2 3 4 5	O
12. Wake up at night	0 1 2 3 4 5	O
13. Lack of a good night's sleep	0 1 2 3 4 5	O
14. Wake up tired	0 1 2 3 4 5	O
15. Fatigue	0 1 2 3 4 5	O
16. Reduced Productivity	0 1 2 3 4 5	O
17. Reduced Concentration	0 1 2 3 4 5	O
18. Frustrated/Restless/Irritable	0 1 2 3 4 5	O
19. Sad	0 1 2 3 4 5	O
20. Embarrassed	0 1 2 3 4 5	O

Please mark the most important items affecting your health by filling in the circles at the end (maximum of 5)

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Allergy History Questionnaire Date ____/____/____

Patient Name _____ DOB ____/____/____

Please check all the appropriate blanks and answer all questions.

Do you have a family history of allergies ____Yes ____No
Describe your symptoms (most bothersome to least):
_____
_____
Are your symptoms __Continuous __Variable __ Year Round __ Seasonal
Is there a worse time of day for your symptoms _____
If your symptoms are seasonal which months are worse _____
Is there a place that your worse (home,work…)_____
Describe the buildings you live/work in
Home_____
Work _____
Do you have Pets? ____Cat(s) ____Dog(s) ____Other:_____
What exposures or changes in your environment do you know or suspect make your symptoms worse or better:
_____
_____
Have you been diagnosed with Asthma ____Yes ____No
Do you have any drug allergies _____
Is there a possibility that you are pregnant or are considering it in the near future ____Yes ____No
Have you taken allergy shots before ____Yes ____No
Have you ever had an anaphylactic / life threatening allergic reaction ____Yes ____No Cause_____
Do you smoke ____Yes ____No Exposed ____Yes ____No