

Patient name: _____

DOB: _____

CONSENT FOR ALLERGY SKIN TESTING

Washington State law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

1. I hereby authorize South Seattle Otolaryngology and/or such assistant(s) to perform skin allergy testing on me.
2. The procedure planned for treatment of my condition(s) have been explained to me. I understand them to be:

Skin Allergy Testing by multiple skin prick tests (applied to upper back) and intradermal dilutional testing (applied to upper arms) to screen me for pollens, molds, animal dander and dust mites. The testing takes approximately 2-2 1/2 hours.

The Multi-TEST II is a sterile, disposable, multiple test head applicator that will be used to deliver the allergenic extract and appropriate controls. The device is firmly applied to the skin on the upper back which may cause some mild discomfort. A positive or “allergic” response to the antigen will manifest as redness and raised wheal or bump at the site of the prick.

The resulting skin response may cause some tenderness and itching. These local effects can be reduced with the application of hydrocortisone cream, and will typically clear in 24 hours. Given the very small amounts of allergenic extract used and the superficial location of each prick, no systemic effects should occur with this screening test.

The intradermal dilutional testing is done on the upper arm(s) to determine the “end point” and severity of your allergy.

I understand that allergy skin testing cannot be performed if I am pregnant, taking antihistamines or beta-blocker medication.

I have read the above and wish to proceed.

PATIENT OR PATIENT REPRESENTATIVE’S ACKNOWLEDGEMENT: I acknowledge that I have read (or read to me) and fully understand the above consent and have had the opportunity to ask questions about the consent form. I understand that my insurance company will be billed the allowable amount for these services and I will be financially responsible for the balance not paid by insurance. If I do not have insurance for the services I will be financially responsible.

SIGNATURE of PATIENT OR

REPRESENTATIVE: _____ **DATE:** _____

WITNESS ACKNOWLEDGEMENT: I acknowledge that I, as witness, have identified the above individual and have observed their signature on this document:

WITNESS SIGNATURE: _____ **DATE:** _____