Allergy Patient Information Packet Combo

Welcome to Allergy Testing Day!

Today you will be tested for the most common 70 environmental and 8 food allergens. The test will take about two minutes to apply to your back using plastic applicators. You will know what you are allergic to in just 15 minutes. Based on the results, your doctor will discuss your treatment plan before you leave the office.

The first step is to fill out the attached forms:

- Consent Form for Allergy Scratch Test
- New Patient Symptom Survey

Below are the most frequently asked questions:

What should I expect during the test?
A clinic staff member will clean the skin testing area with an alcohol pad. When the test is applied to your skin, you will feel slight pressure from the applicator prongs. It will take approximately two minutes to apply the entire test. It will take 15 minutes, after the application of the test, for the results. During this time you will be either lying on your stomach or sitting with the testing area exposed.

How will it feel?
There is slight pressure from the applicators and the test is designed to scratch/prick the first layer of skin. As the test develops, you may experience a temporary itching or a tingling sensation similar to a mosquito bite.

What happens after the test?
After the results are documented, a clinic staff member will wipe off the antigens with alcohol and the itching sensation will start to subside. The marks from the test may remain visible for up to 48 hours. If necessary, you may be offered an antihistamine and/or an anti-itching cream.

How soon will I receive my results?
Your provider will review the results of the allergy test and discuss your treatment options. Together you and your provider will determine the best course of treatment.

Now it's time for your test. You are on your way to learning your allergy triggers!

Consent Form for Percutaneous Testing

By signing below, I give my consent for _____(patient) to have percutaneous testing administered, which has been prescribed by my physician. I acknowledge that an adverse reaction can occur because the test will administer material to which I may be allergic. Although serious reactions are rare, many patients experience an area of local swelling, itching and redness at the site of the prick skin test. This indicates a positive finding. The most sever reaction can involve hives, wheezing, sneezing, itching in the palms of the hands, nose, roof of mouth or throat, or low blood pressure.

It is extremely important that you allow 20 to 30 minutes for the administration of the percutaneous testing and observation. If you cannot wait, you must reschedule your appointment.

By signing below, you give your consent and acknowledge that you have read the information provided to you and that you fully understand the testing process and possible reactions.

Patient Name:_____ Date:_____

Patient of Responsible Party Signature:_____

Allergy Tech Name:_____

Allergy Tech Signature:_____ Date:_____

Percutaneous Testing: Allergy skin testing is a clinical procedure that is used to evaluate an immunologic response to environmental allergens. The need for testing and interpretation of test findings must be correlated with signs and symptoms of possible allergies as determined by a complete history and examination of the patient. The number and type of antigens used for testing are chosen judiciously given the patient's symptoms and the tester's clinical judgement. The Test Kit consists of the top 70 allergens in North America.

Allergy testing is covered when clinically significant allergic history or symptoms that are not controllable by empiric conservative therapy exists (medication only).

For Medicare to cover allergy testing, the following criteria must be met:

1. Testing must correlate specifically to the patient's history and physical findings.

2. The test technique and/or allergens tested must have proven efficacy demonstrated through scientifically valid medical studies published in peer-reviewed literature.

3. Allergy testing must be performed on patients whose environment provides the reasonable probability of exposure to the specific antigen tested.

Percutaneous testing is the usual preferred method for allergy testing. Medicare covers percutaneous (scratch, prick or puncture) testing when IgE-mediated reactions occur to any of environmental allergens such as pollens (trees, weeds and grasses), molds, fungi, animals (dog, cat, cattle, horse or mice dander) or insects (cockroach or dust mites).

New Patient Symptom Survey

Patient Name: _____ Date of Birth: _____

COMMON SYMPTOMS: **Circle the number according to severity: 0=None, 1=Mild, 5=Very Severe**

Abdominal Gas or Cramping	0	1	2	3	4	5		Hives	0	1	2	3	4	5
Arthritis or Muscle Pain	0	1	2	3	4	5		Hyperactivity	0	1	2	3	4	5
Asthma	0	1	2	3	4	5		Itching	0	1	2	3	4	5
Cough	0	1	2	3	4	5		Nasal Congestion	0	1	2	3	4	5
Eczema	0	1	2	3	4	5		Poor Memory or Concentration	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5		Sneezing	0	1	2	3	4	5
Frequent Colds or Sore Throats	0	1	2	3	4	5		Trouble Breathing While Sleeping	0	1	2	3	4	5
Frequent Sinus or Ear Infection	0	1	2	3	4	5		Wheezing	0	1	2	3	4	5
Headache	0	1	2	3	4	5		Watery, Red, Itchy Eyes	0	1	2	3	4	5
Dry Eyes	0	1	2	3	4	5		Burning Eyes	0	1	2	3	4	5

SYMPTOM SCORE: _____ List any other current symptoms:_____

HISTORY:

Are there any foods which cause you any problems? _____
Symptoms: _____
Do you have a history of allergies? ( ) Yes ( ) No If yes, how long have you had allergies? _____
What season(s) do your allergies usually flair up? ( ) Spring ( ) Summer ( ) Fall ( ) Winter ( ) All Year
Have you been allergy tested before? ( ) Yes ( ) No. If yes, when _____
Does any medication give you relief of your allergy symptoms? ( ) Yes ( ) No Comment _____
Do you have pets at home? ( ) Yes ( ) No Type:_____
Are you exposed to fumes or dust? ( ) Yes ( ) No Comment _____
Do you smoke? ( ) Yes ( ) No How much? _____
Are you exposed to smoke in your environment? ( ) Yes ( ) No
Who else in your family has allergies/asthma? ( ) Mother ( ) Father ( ) Sibling ( ) Children
Have you been diagnosed with asthma? ( ) Yes ( ) No If so when? _____ Severity: ( ) Mild
( ) Moderate ( ) High
Do you think your asthma is under control? ( ) Yes ( ) No
How often do you use your inhaler?_____Last date used?_____
Are you taking any sleep aids? (include OTC) _____

CONTRAINDICATIONS:

Do you suffer from uncontrolled asthma or reduced lung function? ( ) Yes ( ) No
Ever had a severe allergic reaction? ( ) Yes ( ) No Hospitalization due to allergies? ( ) Yes ( ) No
Taking Beta Blockers to treat Heart Disease? ( ) Yes ( ) No Medication:_____
Have you taken any allergy, antihistamine, cold medicine or sleep aides in the past 72 hours? ( ) Yes ( ) No
Are you pregnant? ( ) Yes ( ) No ( ) N/A

CLINICAL USE ONLY

Is patient recommended for Allergy Test? ( ) Yes ( ) No Date of Allergy Test _____ Skin ( ) Blood ( )
Refer Patient to a specialist? ( ) Yes ( ) No
Reviewed by: _____ Provider: _____

Patient Schedule Form

You have been scheduled for an allergy test on _____ at _____ AM PM
If you have any questions, concerns, or need to reschedule your appointment, please contact the office.

Please review the "Medications to Avoid" below and address any questions/concerns with your nurse or provider. The following medications can interfere with your test and force the reaction we are looking for to be suppressed.

PLEASE AVOID THESE MEDICATIONS FOR 72 HOURS BEFORE THE DAY OF YOUR TEST

Antihistamines, Cough, Cold, Decongestants or Sleep Aides:

Actifed	Chlor-Trimeton	Nolamine	Sleep Aid
Alavert (loratdine)	Clarinex (desloratadine)	Opcon-A (eye drops)	Tavist
Allega (Fexofenadine)	Claritin (loratadine)	Patanol (eye drops)	Trinalin
Astelin	Codimal DH Syrup	Phenergan	Tylenol Allergy
Atarax	Dimetane Cough Syrup	Periactin	Tussionex
Atrohist	Dura-Vent	Rondec	Tylenol Cold
Benadryl(diphenhydramine)	Extendryl	Rynatan	Tylenol Flu
Bromfed	Hycomine Compound	Ryanatuss	Vistaril
Brompheniramine	Kronofed	Semprex	Xyzal
Chlorpheniramine	Nolahist	Sinulin	Zyrtec (96 hours)

Nasal Sprays:

Astelin	Aster	Patanase

Sleep Aides: Avoid all over the counter sleep aides, ie Tylenol PM, Equate PM, etc. They all have Diphenhyrdramine as the active ingredient.

Beta Blockers – cannot be taken within the 24 hours prior to testing. Take your medication the morning before the test prior to _____ AM and on the day of the test bring your medication with you. After the testing is completed and the office has released you to leave, you may take your Beta Blocker.

Patient Signature: _____ Date: _____

Environmental/Food Combo Test Kit Panel

PATIENT NAME: _____

PATIENT ID_____

TESTING DATE:_____/_____/_____

Insurance:_____

Preauthorized: Yes [ ] No [ ]

Taking Antihistamines: Yes [ ] No [ ]

Testing Rescheduled: Yes [ ] No [ ] Date Test:_____

History of Asthma: Yes [ ] No [ ]

Spirometry Requested: Yes [ ] No [ ]

Spirometry Performed: Yes [ ] No [ ]

Skin Testing Consent Signed: Yes [ ] No [ ]

Immunotherapy Consent Signed: Yes [ ] No [ ]

Billable Procedures:

[ ] 95004 - Skin Test x 80 Units

Upper Respiratory:

( ) J20.9	Acute Bronchitis
( ) R05	Cough Extrinsic
( ) J45.998	Asthma Extrinsic or Unspecified
( ) J11.0	Influenza URI Acute
( ) J17	Pneumonia
( ) J45.90	Asthma, Unspecified
( ) J06.9	URI w/ Multiple Sites
( ) R06.2	Wheezing

Ear:

( ) H66.90	Otitis Media, Unspecified
( ) H65.00	Serous Otitis Media Acute
( ) H65.20	Serous Otitis Media Chronic

Eye:

( ) H10.3	Acute Atopic Conjunctivitis
( ) H10.45	Chronic Atopic Conjunctivitis

GI:

( ) K52.2	Allergic Gastroenteritis (Food)
( ) K90.0	Celiac
( ) R11.10	Vomiting, Unspecified

Skin

( ) L20.89	Atopic Dermatitis
( ) L25.9	Contact Dermatitis
( ) L27.2	Dermatitis, Food
( ) L27.0	Dermatitis, Medication
( ) L22	Diaper Dermatitis
( ) L25.5	Plant Contact
( ) L50.0	Urticaria/Angioedema Allergic
( ) L50.8	Urticaria, Unspecified

Allergic Rhinitis:

( ) J31.0	Chronic Rhinitis
( ) J30.1	Rhinitis due to pollen (Hay fever)
( ) J30.81	Rhinitis due to animal dander
( ) J33.0	Nasal Polyps
( ) J34.3	Hypertrophy of Nasal Turbinates

Sinus:

( ) J32.0	Chronic Sinusitis
( ) J01.9	Acute Unspecified Sinusitis
( ) J32.9	Chronic Unspecified Sinusitis
( ) R09.82	Post Nasal Drip

PANEL A: CONTROLS & GRASS POLLENS			PANEL B: WEED POLLENS 1			PANEL C: WEED POLLENS 2		
A1	+ CONTROL, HISTAMINE		B1	ALFALFA POLLEN		C1	PIGWEED, ROUGH	
A2	- CONTROL, GLYCERINE		B2	BAYBERRY (WAX MYRTLE)		C2	RAGWEED, GIANT (TALL)	
A3	BAHIA GRASS		B3	COCKLEBUR		C3	RAGWEED, FALSE	
A4	BERMUDA GRASS		B4	ENGLISH PLANTAIN		C4	RAGWEED, SHORT	
A5	JOHNSON GRASS		B5	KOCHIA (FIREBUSH)		C5	RAGWEED, WESTERN	
A6	KENTUCKY BLUE/JUNE GRASS		B6	LAMBS QUARTER		C6	RUSSIAN THISTLE	
A7	PERENNIAL RYE GRASS		B7	MARSHELDER, ROUGH		C7	SHEEP SORREL	
A8	TIMOTHY GRASS		B8	MUGWORT, COMMON		C8	SAGEBRUSH, COMMON	
PANEL D: TREE POLLENS 1			**PANEL E: TREE POLLENS 2**			**PANEL F: TREE POLLENS 3**		
D1	ALDER, WHITE		E1	CYPRESS, BALD		F1	OAK, WHITE	
D2	ASH, WHITE		E2	ELM, AMERICAN		F2	OLIVE TREE	
D3	BIRCH, WHITE		E3	ELM, CHINESE		F3	PALM, QUEEN	
D4	BIRCH, RED RIVER		E4	HICKORY, SHAGBARK		F4	PECAN TREE POLLEN	
D5	BOX ELDER		E5	JUNIPER WESTERN		F5	PINE WHITE	
D6	CEDAR, RED		E6	MAPLE, SUGAR POLLEN		F6	PINE AUSTRALIAN	
D7	CEDAR, MOUNTAIN		E7	MULBERRY RED		F7	POPLAR, WHITE	
D8	COTTONWOOD, EASTERN		E8	OAK, LIVE VIRGINIA		F8	PRIVET	
PANEL G: TREES, MOLDS & FUNGI			**PANEL H: OUTDOOR,MOLDS & FUNGI 2**			**PANEL I: ANIMALS & INSECTS**		
G1	SYCAMORE, AMERICAN		H1	FEATHER MIX		I1	CAT HAIR	
G2	WALNUT, BLACK POLLEN		H2	BIPOLARIS SOROKINIANA		I2	CATTLE EPITHELIUM	
G3	WILLOW, BLACK		H3	EPICOCCUM NIGRUM		I3	COCKROACH MIX	
G4	ALTERNARIA TENIUS		H4	GIBBERELLA PULICARIS		I4	DOG EPITHELIUM	
G5	ASPERGILLUS FUMIGATUS(M)		H5	MUCOR PLUMBEUS		I5	HORSE EPITHELIUM	
G6	CANDIDA ALBICANS		H6	PENICILLIUM, NOTATUM (F)		I6	MITE FARINAE	
G7	SAROCLADIUM STRICTUM		H7	CORN SMUT		I7	MITE PTERONYSSINUS	
G8	CLADOSPORIUM, (F)		H8	PULLULARIA, AUREOBASIDIUM		I8	MOUSE EPITHELIUM	

PANEL J: FOOD			PANEL J: FOOD			PANEL J: FOOD		
J1	BAKERS YEAST		J4	COW MILK		J7	SOYBEAN	
J2	BARLEY		J5	EGG WHITE		J8	WHOLE WHEAT	
J3	CORN		J6	RICE				

TestKit Results Guide:

11mm+: Extremely High Allergy **9mm:** Very High Allergy **7mm:** High Allergy **5mm:** Moderate Allergy **4mm:** Low Allergy **<4mm: Trace Allergy**

Test Completed By:_____

Test Reviewed By:_____