Allergy Questionnaire

Name: ______________________________________ DOB: _______________ Date: _____________

- **Have you ever had an adverse reaction to allergy skin testing?** YES _____ NO______
- **Have you ever had an allergic reaction or allergic symptoms that required medical attention?** YES _____ NO______
- **Have you ever received allergy shots or sublingual drops?** YES _____ NO______
  - If **Yes**, specify the years you received treatment: From ________ to ____________
  - If **Yes**, did you have any adverse reactions: YES _____ NO______
- **Do you have any known food allergies or food intolerance?** YES _____ NO______
  - If **Yes,** please specify type of food, type of reaction, and dates of when last reaction occurred:

    ____
- **For Women**- Could you be pregnant? / Trying to become pregnant? YES _____ NO______

CURRENT MEDICATIONS: (including nasal sprays, inhalers, allergy medications, OTC cough and cold medications, and sleep aids)

- Over the counter medications: ____
- Are you currently taking any Beta Blockers? YES _____ NO______
  - If yes, please note name of medication: ________________________________ Time of last dose:_________
- Medication list attached: YES _____ NO______

Are you currently or have you recently experienced any of the below symptoms? (Please check all that apply)

- ❏ Decreased taste/ smell
- ❏ Hearing loss
- ❏ Cough
- ❏ Wheezing
- ❏ Shortness of breath
- ❏ Chest tightness
- ❏ Sneezing
- ❏ Nausea
- ❏ Itching or clogged ears
- ❏ Recurrent ear infections
- ❏ Runny nose
- ❏ Nasal congestion
- ❏ Indigestion
- ❏ Itchy/Watery eyes
- ❏ Post nasal drip
- ❏ Weight gain/loss
- ❏ Food allergies
- ❏ Skin sensitivity
- ❏ Dry or itchy skin
- ❏ Joint pain
- ❏ Dizziness
- ❏ Sinus infections
- ❏ Fatigue
- ❏ Diarrhea
- ❏ Dermatographism
- ❏ Throat clearing
- ❏ Heartburn
- ❏ Hives/Rash
- ❏ Headaches
- ❏ Snoring
- ❏ Constipation
- ❏ Other _______________

- **Are your allergy symptoms?**

❏ Currently present ❏ Seasonally ❏ All year long ❏ Worsening

- **Circle the months that your symptoms are the worst:** JAN FEB MAR APR MAY JUN JULY AUG SEPT OCT NOV DEC

YOUR PAST MEDICAL HISTORY: (Please check all that apply)

- ❏ Autoimmune disorder
- ❏ Thyroid disorder
- ❏ Asthma
- ❏ Seizures
- ❏ Emphysema/COPD
- ❏ Gynecological disorders
- ❏ Food allergy/ Intolerance
- ❏ Respiratory infections
- ❏ Hypertension
- ❏ Arthritis
- ❏ Anxiety/Depression
- ❏ Allergies
- ❏ COVID
- ❏ GI disorder
- ❏ Heartburn/ Reflux
- ❏ Migraines
- ❏ Kidney disease
- ❏ Fibromyalgia
- ❏ Diabetes
- ❏ Cancer
- ❏ ADD/ADHD
- ❏ Irritable bowel
- ❏ Other _______________

FAMILY HISTORY Who in your family has had symptoms or experienced: (**NOT** including yourself)

Asthma:	**Eczema:**	**Seasonal Allergies:**	**Sinus Problems:**	**Drug/Food Allergies:**
❏ Mother/ Father	❏ Mother/ Father	❏ Mother/ Father	❏ Mother/ Father	❏ Mother/ Father
❏ Siblings	❏ Siblings	❏ Siblings	❏ Siblings	❏ Siblings
❏ Grandparents	❏ Grandparents	❏ Grandparents	❏ Grandparents	❏ Grandparents
❏ Children	❏ Children	❏ Children	❏ Children	❏ Children

Allergy Use Only:

Questionnaire reviewed: _______________ Send to testing: YES _____ NO______ EMR Note: YES _____ NO______

Patient Information/Consent Form for Allergy Skin Testing

Name: ____ MR#________ DOB:_________________

PLEASE READ AND BE CERTAIN THAT YOU UNDERSTAND THE FOLLOWING INFORMATION PRIOR TO SIGNING THIS CONSENT FOR TESTING.

PURPOSE:

Allergy skin testing is a method of testing for allergy antibodies. Allergies antibodies are produced by your immune system after repeated exposure to allergic substances (e.g. pollen, cat dander). Not all people have allergic antibodies and not everyone with allergies will produce antibodies to allergic sources. Allergy skin testing helps to confirm which substance (if any) may be causing your allergy symptoms.

The results of the skin test will be correlated with your clinical history and description of allergy symptoms. Positive tests indicate the presence of allergic antibodies, but a positive skin test result does not necessarily indicate that the allergen will cause symptoms.

METHOD

The allergy skin test method used in this clinic is the Skin Prick Method, where the skin is pricked with a disposable plastic applicator that delivers a very small amount of allergenic extract into the skin surface. Each applicator tests an individual allergen and as many as 40 applicators will be applied to your arms or back. No needles are used in this method.

ALLERGENS

You will be tested on a variety of important airborne and/ or food allergens. These include pollen (from trees, grasses & weeds), molds, dust mites, and animal dander. The allergens in your testing panel represent the most common inhalant and/or food allergens for your region as well as many common allergens found in residential and work environments. If you believe that you have a specific food allergy, you should discuss this with your provider.

EXPECTATIONS

An allergy skin test consists of introducing small amounts of the suspected allergenic substance (i.e. allergenic extract) into the skin and noting the developments of a positive reaction which consists of mild swelling and redness (similar to a mosquito bite). The procedure takes less than 10 minutes to administer and the results are read approximately 15 to 29 minutes after the application of the allergen.

Any positive reactions will gradually disappear over a period of 30 to 60 minutes and typically, no treatment is necessary for the itchiness. Most patients report the testing to be pain free though you may feel a pricking sensation during the application of the allergen, and many patients will experience some itching. The testing nurse will provide a cream or spray to help relieve itching after the test results have been recorded. In rare cases, some local swelling may occur several hours after the skin tests are applied. These reactions are not serious and will disappear over the next week or so. They should be measured and reported to your physician at your next visit.

MEDICATIONS TO AVOID

1. No prescription or over the counter oral antihistamines should be used 4 to 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, Allegra, Zyrtec, Actified, Dimetapp, Benadryl, and many others. Prescription antihistamines such as Clarinex and Xyzal 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 doctor.
2. Medications such as over the counter sleeping medications (e.g. Tylenol PM) also contain active ingredients that interfere with histamine and these should not be taken within 3 days of your scheduled skin test.
3. You should discontinue your nasal and eye antihistamine medications, such as Patanase, Pataday, AStepro, Optivar, or AStelin at least 2 days before the testing.
4. Other prescription drugs such as amitriptyline hydrochloride (Elavil), hydroxyzine (Atarax), doxepin (Sinequan), and imipramine (Trofranil) have antihistaminic activity and should be discontinued at least 2 weeks prior to receiving a skin test. Do not skip taking these medications before consulting with your physician first.

MEDICATION TO BE CONTINUED

1. You may continue to use your intranasal allergy sprays such as Flonase, Rhinocort, Nasonez, Nasacort, Omnaris, Veramyst and Nasarel.
2. Asthma inhalers (inhaled steroid and bronchodilators), leukotriene antagonists (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 (bring a list if necessary)

ADVERSE REACTIONS

Although adverse reactions to skin testing are rare, your test will be administered at this medical facility with a medical physician or other healthcare professional present since occasional reactions may require immediate intervention. 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; fairness;

nausea or vomiting; hives; generalized itching; and shock, the later under extreme circumstances. Please let your physician know if you are pregnant or taking beta-blockers.

Allergy skin testing may be postponed until after the pregnancy in the unlikely event of reaction to the allergy testing and beta-blockers are medication they may make 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.

ADDITIONAL INFORMATION
After skin testing, you will consult with your physician or other healthcare professional to discuss further recommendations regarding your treatment.

We request that you don't 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/ waiting room.

Please do not cancel your appointment since the time set aside for your skin testing is exclusively your for which special antigens are prepared. If for any reason you need to change your skin test appointment, please give us at least 48 hours notice, due to the length of time scheduled for skin testing, a last minute change results in a loss of valuable time that another patient might have utilized.

IMPORTANT MEDICATION TO INFORM US IF YOU ARE TAKING
Beta-blocker: Examples: Lopressor [metoprolol], Coreg [carvedilol], Tenormin [atenolol], some glaucoma eye drops.

Some antidepressants or Monoamine oxidase inhibitors.

OTHER IMPORTANT INFORMATION
- Fasting is not necessary, but please avoid sunburns or excessive sun exposure immediately before allergy skin testing.
- Please bring in a list of your current medications.
- Please let us know if:
    - You are or possibly are pregnant
    - Wheezing or have a fever

CONSENT FOR ADMINISTRATION OF ALLERGY SKIN TESTING (SKIN PRICK TESTING) AUTHORIZATION FOR TESTING
I have read the information in this consent form and understand it. The opportunity has been provided for me to ask questions regarding the potential risks of allergy skin testing and these questions have been answered to my satisfaction. I understand that precautions with the best medical practices will be carried out to protect me from adverse reactions to skin testing. I do hereby give consent for the patient designated below to be tested with allergenic extracts by skin prick testing, as recommended by a physician.

____Print ________________________
ed Name of Allergy Patient Medical Record Number

____ ________________________
Patient Signature (or parent/legal guardian) Date Signed

____ ________________________
Witness Date Signed

FOR OFFICE USE ONLY
I certify that I have counseled this patient and/or authorized legal guardian concerning the information in the Consent for Allergy Skin Testing and that it is in my opinion that the signee understands the nature, risks and benefits of the proposed diagnostic procedure.

____ ________________________
Technician Name **Date Signed**

Encounter Form

Client #: SICL- 142 St. Luke's Regional Health Provider: Dr. Joseph Ghaly / Nkechinyere Esoga, APRN / Julianna Carter, PA-C **Date:**______________ **ACCT#** ____________

Patient Name: ____ **Date of Birth:**________________ **Insurance Co:** ______________________

Office Visit		**CPT**		**Immunotherapy**		**CPT**	
			Saw Dr. Joseph Ghaly				
	Brief 15 Min	99211	Saw Jeanette Diyorio, APRN		Single Injection	95115	TWG / ME 0.______cc RT/ LT Arm #______
	Ltd. 15-30 Min	99212	Saw Julianna Carter, PA-C		2+ Injection	95117	TWG / ME 0.______cc RT/ LT Arm #______
Allergy Testing		**CPT**		**Allergy Treatment**		**CPT**	**PT REFUSED TX / NO TX REQUIRED**
	Aero Panel	95004	40 Units #of RX: __________		104 Doses	95165	
	Food Panel	95004	40 Units #of RX: __________		156 Doses	95165	*Not to exceed maximum units allowed by carrier
	Pediatric Panel	95004	22 Units #of RX: __________		208 Doses	95165	*Not to exceed maximum units allowed by carrier

Code	Description	Code	Description	Code	Description	Code	Description
H10.411	Chronic giant papillary conjunctivitis, RT Eye	**H65.492**	Other chronic nonsuppurative otitis media, LT Ear	**J44.1**	Chronic obstructive pulmonary disease with (acute) exacerbation	**L27.2**	Dermatitis due to ingested food
H10.412	Chronic giant papillary conjunctivitis, LT Eye	**H65.493**	Other chronic nonsuppurative otitis media, B/L	**J45.20**	Mild intermittent asthma, uncomplicated	**L29.9**	Pruritus, unspecified
H10.413	Chronic giant papillary conjunctivitis, B/L	**H68.021**	Chronic Eustachian salpingitis, RT Ear	**J45.21**	Mild intermittent asthma with (acute) exacerbation	**L50.0**	Allergic urticaria
H10.45	Other chronic allergic conjunctivitis	**H68.022**	Chronic Eustachian salpingitis, LT Ear	**J45.22**	Mild intermittent asthma with status asthmaticus	**L50.1**	Idiopathic urticaria
H65.04	Acute serous otitis media, recurrent, RT Ear	**H68.023**	Chronic Eustachian salpingitis, B/L	**J45.30**	Mild persistent asthma, uncomplicated	**L50.6**	Contact urticaria
H65.05	Acute serous otitis media, recurrent, LT Ear	**J30.0**	Vasomotor rhinitis	**J45.31**	Mild persistent asthma with (acute) exacerbation	**L50.8**	Other urticaria
H65.111	Acute and subacute allergic otitis media, RT Ear	**J30.1**	Allergic rhinitis due to pollen	**J45.32**	Mild persistent asthma with status asthmaticus	**L50.9**	Urticaria, unspecified
H65.112	Acute and subacute allergic otitis media, LT Ear	**J30.2**	Other seasonal allergic rhinitis	**J45.40**	Moderate persistent asthma, uncomplicated	**R05**	Cough
H65.113	Acute, subacute allergic otitis media, B/L	**J30.5**	Allergic rhinitis due to food	**J45.41**	Moderate persistent asthma with (acute) exacerbation	**R06.02**	Shortness of breath
H65.114	Acute and subacute allergic otitis media, RT Ear	**J30.81**	Allergic rhinitis due to animal (cat) (dog) hair and dander	**J45.42**	Moderate persistent asthma with status asthmaticus	**R06.2**	Wheezing
H65.115	Acute and subacute allergic otitis media, recurrent, LT Ear	**J30.89**	Other allergic rhinitis	**J45.50**	Severe persistent asthma, uncomplicated	**R09.81**	Nasal congestion
H65.116	Acute and subacute allergic otitis media, B/L	**J31.0**	Chronic rhinitis	**J45.51**	Severe persistent asthma with (acute) exacerbation	**R21**	Rash and other nonspecific skin eruption
H65.194	Other acute nonsuppurative otitis media, recurrent, RT Ear	**J33.1**	Polypoid sinus degeneration	**J45.52**	Severe persistent asthma with status asthmaticus	**R23.8**	Other skin changes
H65.195	Other acute nonsuppurative otitis media, recurrent, LT Ear	**J33.8**	Other polyp of sinus	**J45.991**	Cough variant asthma	**R23.9**	Unspecified skin changes
H65.196	Other acute nonsuppurative otitis media, recurrent, B/L	**J34.1**	Cyst and mucocele of nose and nasal sinus	**J45.998**	Other asthma	**R43.8**	Other disturbances of smell and taste
H65.21	Chronic serous otitis media, RT Ear	**J34.81**	Nasal mucositis (ulcerative)	**L20.0**	Besnier's prurigo	**R43.9**	Unspecified disturbances of smell and taste
H65.22	Chronic serous otitis media, LT Ear	**J35.01**	Chronic tonsillitis	**L20.81**	Atopic neurodermatitis	**G43.9**	Migraine Unspecified
H65.23	Chronic serous otitis media, B/L	**J35.02**	Chronic adenoiditis	**L20.82**	Flexural eczema	**M06.9**	Migraine, Unspecified
H65.411	Chronic allergic otitis media, RT Ear	**J35.03**	Chronic tonsillitis and adenoiditis	**L20.84**	Intrinsic (allergic) eczema	**I10**	Hypertension, Unspecified
H65.412	Chronic allergic otitis media, LT Ear	**J35.1**	Hypertrophy of tonsils	**L20.89**	Other atopic dermatitis	**E11.9**	Diabetes
H65.413	Chronic allergic otitis media, B/L	**J35.2**	Hypertrophy of adenoids	**L72.2**	Dermatitis due to ingested food	**E66.9**	Obesity, Unspecified
H65.491	Other chronic nonsuppurative otitis media, RT Ear	**J35.3**	Hypertrophy of tonsils with hypertrophy of adenoids	**Other DX:** ____			

Providers Signature: ____

*Not to exceed maximum units allowed by carrier for current medical necessity requirements, varies by carrier.

Consent for Allergy Treatment

Patients Name: ____ **DOB:** __________________________

My physician has recommended the following procedure/treatment: ALLERGY IMMUNOTHERAPY.

S/he explained to me that the potential benefits and any risks of the Allergy Immunotherapy, which include but are not limited to:

Continual chronic allergy symptoms without relief, Allergic Rhinitis, and other potential allergy symptoms.

By signing this document, I acknowledge at (1) my medical condition has been evaluated and explained to me by the physician who has recommended treatment as stated above, (2) my physician has explained to me the potential benefits of such treatment and the risks associated with it, (3) my physician has explained to me the possible risks of not following through with the recommended treatment, and (4) I have had an opportunity to discuss any and all questions related to the recommended treatment.

(PLEASE CHECK ONE OF THE FOLLOWING & PRINT PATIENT NAME)

- I, ____, acknowledge the fact, with my signature, that I am authorizing my physician to start the billing and ordering process' to begin allergy immunotherapy.

- I, ____, despite the above referenced information, refuse or decline to consent to this allergy immunotherapy.

$____________ Remaining Deductible ___________ % Coinsurance ________________(Patient Initials)

____ ______________________________

Patient, Parent or Caregiver Signature **Date**

____ ______________________________

Witness Signature **Date**

Medical Necessity

On ________________, I sent ____, DOB: ______________; for surface antigen Allergy Testing. The patient had chronic allergic symptoms unrelieved by over the counter or prescription medications. The tests indicated a positive response to the aeroallergens (see attached test results) and dosing structure was determined based on medical guidelines for the type of allergens identified.

The treatment will include weekly visits for injection(s) for a min of 27 weeks with continued monthly injection(s) for the remainder of the year. These weekly injections could continue longer based on patient outcomes or antigen reactions. If needed, dosing will be adjusted until the patient resolves local, allergic or systemic adverse reactions (dermal surface or other responses).

Injection schedules have been predetermined by current AAAAI guidelines for immunotherapy antigen administration for both volume and duration. Medication will be compounded under USP 797 2016 guidelines.

The patient had explained in detail both the risks and benefits of Immunotherapy treatment, the duration and the possible outcomes of therapy. They were also informed about continued testing and treatment until antibody levels for the allergens listed have stabilized and a negative response to testing and chronic symptoms have been resolved.

Additional Provider Notes: ____

Pt had _____ reactions to Aeroallergens, which included / did not include pseudopods.

Pt had _____ food reactions, which included / did not include pseudopods.

☐ **Patient agrees to immunotherapy**.

☐ **Patient declines to immunotherapy**.

☐ **Immunotherapy not recommended at this time.**

____

____

______________________________ ____________________

Physician Signature **Date**

ST LUKE'S REGIONAL HEALTH CARE

Technician Checklist

- Questionnaire complete (page1):
  - All questions answered
  - Medications listed, attached
- Consent form (page 2) :
  - Signed by patient/ parent/ guardian
- Encounter Form (page 3):
  - Testing Codes
  - Treatment Codes
  - Diagnosis Code(s)
  - MR#
- Aero panel (page 4):
  - + and - controls both measured, if negative shows no wheal or flare record 0x0
  - Positive Reaction greater than 3x3
  - Negative Reactions records individually
  - # of dosages matches the encounter form
  - Pseudopods identified with "P"
  - Positive reactions identified with ✶
- Food Panel (page 5):
  - + and - controls both measured, if negative shows no wheal or flare record 0x0
  - Positive Reaction greater than 3x3
  - Negative Reactions records individually
  - Pseudopods identified
  - Positive reactions identified with ✶
- Consent for Treatment (page 6):
  - Patient name printed line 1 accept or line 2 decline
  - Signed by patient / parent/ guardian
- Medical Necessity (page 7):
  - # of Aero reactions
  - # of Food reactions
  - Accept or declined immunotherapy
- Provider signatures on correct pages:
  - Encounter Form(3)
  - Aero Panel (4)
  - Food Panel (5)
  - Medical Necessity (7)
- Demographics/ Insurance Card and Photo ID Included in packet (page 8)
- DCAP Entry:
  - Patient name is spelled same as packet
  - Date of Birth is same as packet
  - MR#
  - Notes
- File labeled correctly in Daily Testing folder
  - Last name, First name

____

Technician Signature