

# NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES



## TEXAS HEALTH RESOURCES DALLAS

Professional Building 2  
8220 Walnut Hill Lane, Suite 101  
Dallas, TX 75231  
Tel: (214) 369-1901

## BAYLOR PLANO

Pavilion 1  
4708 Alliance Blvd, Suite 610  
Plano, TX 75093  
Tel: (972) 596-4383

Fax: (214) 369-1905

Web: [www.texasallergyonline.com](http://www.texasallergyonline.com)

## INFORMED CONSENT FOR IMMUNOTHERAPY

I (we) request North Texas Allergy & Asthma Associates and/or my primary care doctor to administer the allergy immunotherapy program ("immunotherapy") also known as allergy shots.

I (we) understand that immunotherapy may result in complications of anaphylaxis and even death. The American Academy of Allergy, Asthma, and Immunology recommends that immunotherapy be given under a physician's supervision. This practice believes this position is medically appropriate and that you should always obtain your injection by trained personnel, either in our office or another medical setting. Thus, I (we) understand that the immunotherapy is to be administered under a physician's supervision.

Furthermore, I (we) understand that it is required for me to wait in the waiting room **AT LEAST 20 MINUTES** after each allergy injection. If I (we) leave early, I (we) understand that it is against medical advice and will hold my treating physician and North Texas Allergy & Asthma Associates and their staff free of any liability.

In the event that I (we) receive immunotherapy, I (we) will notify the doctor or staff immediately if I (we) have any allergic reactions to my injections so that proper treatment can be initiated. I (we) understand that any time immunotherapy is given; there is a rare chance of nicking a tiny blood vessel causing a bruise, numbness or pain. If swelling is over 2 inches at the site of injection, I (we) will notify the nurse or physician before receiving my next injection.

I (we) understand that as a patient taking immunotherapy, I (we) should not use Beta-Blockers because of the inability to treat an allergic reaction, including hypotension or shock. I (we) also understand that while taking immunotherapy I (we) should not use MAO Inhibitors drugs for depression unless specifically approved by my treating physician at North Texas Allergy & Asthma Associates since such drugs may cause high blood pressure when adrenalin or other prescription medications are administered.

I (we) have been given the opportunity to ask questions about my condition and treatment, alternative forms of treatment, the procedures to be used, and the risks and hazards involved, I (we) believe that I (we) have sufficient information to give this informed consent. I (we) acknowledge that this disclosure and informed consent has been fully explained to me, that I (we) have read it or have had it read to me and I (we) understand its contents.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

If minor, Name of Legal Guardian: \_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_