

Clinic Logo Here

Clinic Name Here

Patient Consent to Desensitization

My medical condition and the procedure which I will be having has been explained to me by Dr. _____. I understand the risks and benefits that I can reasonable expect from this procedure.

I understand that among the risks of this procedure are immediate reactions, delayed reactions, severe allergic reactions, and other reactions. I also understand that, as with every procedure, there is a possibility of unexpected complications.

The following specific risks and issues were discussed with me:

IMMEDIATE REACTIONS: The risks of an immediate allergic reaction include: Itching, rash, hives, swelling of the lips, tongue, or throat, chest pain, chest tightness, shortness of breath, wheezing, abdominal pain, nausea, vomiting, diarrhea, palpitations, dizziness, confusion, anaphylaxis, shock and death.

DELAYED REACTIONS: Additional delayed reactions can include: rash, itching, liver or kidney involvement, fevers, chills, joint pains, and ulcerations.

There is a risk of other types of allergic reactions as a result of side effects of the medication or food, and may include the following:

Doctor _____ will perform my procedure.

I have had an opportunity to ask about the risks and benefits of this procedure and of the alternatives. All my questions have been answered to my satisfaction, and I consent to this procedure.

Date _____ Time _____ AM/PM _____

Signature (patient/health care agent/guardian/family member)
(If patient's consent cannot be obtained, indicate reason above)

I attest that I discussed all relevant aspects of this procedure, including the indications, risks, and benefits, as compared with alternative approaches, with the patient, and answered his/her questions.

Date _____ Time _____ AM/PM _____

Signature (Physician/Licensed Practitioner)

From the ACAAI 2015 Drug Allergy and Anaphylaxis Committee