ENT & Allergy
ASSOCIATES, S.C.

EAR, NOSE & THROAT | ALLERGY & ASTHMA | HEARING CENTER
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Venom Immunotherapy Patient Consent
(Venom Allergy Injections)

I, _____ am acknowledging that I will begin my venom immunotherapy treatment.

I, _____ parent/guardian of _____ am acknowledging that they will begin venom immunotherapy treatment.

The following points regarding venom immunotherapy were reviewed and discussed in detail:

- The process and purpose of the venom immunotherapy treatment program
- The risk of the treatment, including the possibility of an allergic reaction (anaphylaxis) as well as the risk that the treatment program may not accomplish the desired goals.
- The possible outcome of the treatment
- The available alternative medical treatments
- The prognosis if the program is not followed
- The need for regular follow up
- Risk of anaphylaxis (allergic reaction) and use of injectable epinephrine, with proper demonstration of epinephrine auto injector
- Office polices regarding venom immunotherapy
- Financial policy: it is the patient's responsibility to provide up to date insurance information, and balances need to be current at the time of remixing serum. If you choose to discontinue allergy injections, you will still be responsible for any prior balances incurred

I have had sufficient opportunity to discuss my condition with my allergist and all my questions have been answered to my satisfaction. I have read and understand the Administration of Venom Immunotherapy information handout. I believe that I have the adequate knowledge upon which to base an informed consent to this program.

I consent to other diagnostic and treatment procedures and the monitoring program that the physician decides might be necessary due to unexpected conditions (such as treatment of an allergic reaction).

I have read and fully understand this form.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Patient Signature (or Legal Guardian) Date

_____ _____
Witness Date