ALLERGY, ASTHMA, AND IMMUNOLOGY INNOVATIONS

Neha Yakhmi, MD
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Intralymphatic Immunotherapy Consent

I (patient or parent, legal guardian, or power of attorney who is executing this Consent Form on the patient's behalf) hereby consent to the performance of intralymphatic immunotherapy (ILIT).

1. Background Information: I understand that ILIT is a form of allergen immunotherapy in which allergen extracts are injected directly into the inguinal lymph nodes under ultrasound guidance. I understand that a complete course of ILIT is a series of three injections given four weeks apart, but symptom improvement may not occur for several months. I understand that I may have complete or partial relief of symptoms, but in rare cases, may have no significant improvement in allergy symptoms. I also understand that ILIT is not a replacement for other treatment measures such as environmental avoidance and medications.

I understand this is an alternative to traditional allergy shots allowing for lower doses of allergens and fewer injections. I understand that while this uses the same extracts as traditional allergy shots, this method is not yet FDA approved for treatment of allergic rhinitis.

I understand the proposed treatment, expected outcomes, material risks and side effects of immunotherapy, as well as the potential alternatives to immunotherapy. I have had the opportunity to ask questions regarding immunotherapy and my questions have been answered to my satisfaction.

2. Reactions: I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions. I also agree that if I have an allergic reaction to the injections that the physician-in-charge has permission to treat said reaction.

I understand that the most common reactions occur at the site of injection and can include swelling and itching. Rarely, other reactions may occur, including bruising, infection, hives, swelling, shortness of breath, or loss of consciousness. Rarely, a life-threatening reaction called anaphylaxis may occur.

I understand that I am required to remain in the office under close observation for a minimum of **one hour** after each set of injections. I also understand that I am to report any problems that I may be experiencing to medical staff immediately.

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3. Medical Contraindications: I understand that I should not receive an injection if I am currently ill (for example, with fever/chills, wheezing, or hives). I also understand that I should not receive an injection if I am currently having asthma symptoms, such as cough, wheezing, or shortness of breath.

4. Billing/Payment: I understand that my allergic extract prescription is prepared according to my specific sensitivities and is not usable by any other patient. I understand that once the extracts are prepared, I am liable for the expense. I also understand that payment is due at the time of service and that insurance will not be billed for these services.

5. Patients Under Age 18: I understand if the patient is 17 years of age or younger, I (parent or legal guardian) must be present during the sixty (60) minute waiting period after the injection.

6. Medications/Beta Blockers: I understand that ILIT will not be administered to any patients currently taking beta blockers. By signing this consent, I verify that I am not taking beta blocker medications.

7. Pregnancy: If I am to become pregnant during my time on immunotherapy, I will inform the office immediately. I understand that further ILIT injections will not be given while pregnant.

8. Contents and Withdrawal: I understand the contents of this consent form. I understand that I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction. I understand that I can withdraw this consent at any time.

Patient Name: _____ DOB: _____

Parent/Guardian: _____

Signature: _____ Date: _____

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