ALLERGY, ASTHMA, AND IMMUNOLOGY INNOVATIONS

Neha Yakhmi, MD
Kokomo: 2216 W. Alto Road, Kokomo, IN 46902
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Sublingual 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 sublingual immunotherapy (SLIT).

1. Background Information: I understand that SLIT is a form of allergen immunotherapy in which allergen extracts are mixed into serum and administered daily under the tongue to encourage tolerance of those allergens. I understand this is an alternative to traditional allergy shots allowing for home administration and avoidance of needles. I understand that while this uses the same extracts as traditional allergy shots, this method is not 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 SLIT, I will notify my physician immediately and stop SLIT therapy until discussed and further instructed by them.

I understand that the most common reaction is mild itching of the mouth, throat, or ears. Rarely, other reactions may occur, including hives, swelling, shortness of breath, or loss of consciousness. Very rarely, a life-threatening reaction called anaphylaxis may occur.

3. Medical Contraindications: I understand that there may be certain medical contraindications to continuing SLIT and that if I receive any new medical diagnoses or am started on any new medications, I will notify my physician immediately.

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 will be collected on a monthly basis until therapy is discontinued, and that insurance will not be billed for these services.

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5. Medications/Beta Blockers: I verify that I am not taking beta blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician. A shared and informed decision will be made together with my physician regarding taking that medication, and I will abide by that decision.

6. Pregnancy: If I am to become pregnant during my time on immunotherapy, I will inform the office immediately. I understand that while pregnant, my immunotherapy dose will be kept the same and not increased.

7. 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 (if applicable): _____

Relationship to patient: _____

Signature: _____ Date: _____

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