BUCKS ENT ASSOCIATES P.C.
3 CORNERSTONE DRIVE
LANGHORNE, PA 19047
P-267-689-1000
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INSTRUCTIONS FOR ALLERGY TESTING

- Please note that coverage for allergy testing and immunotherapy varies by each insurance company. Prior to allergy testing you are responsible for contacting your insurance company regarding your benefits for allergy testing or immunotherapy. The test codes are as follows:

  Allergy skin test/M.Q.T. : 95004 x32 (32 is the amount of allergens we are testing for)
  Allergy injection: 95115
  Allergy injections: 95117
  Vial or Serum: 95165
  Vial test injection: 95024

- The method of allergy skin testing that our office performs is M.Q.T. (modified quantitative testing). This method of testing involves little or no pain however, positive reactions can cause itchy red bumps that can look and feel like mosquito bites. The itching and bumps are usually gone shortly after the test but can last up to 24 hours. Allergens are applied to the skin using a plastic applicator. A timer is set for twenty minutes giving the skin enough time to react. After the twenty minutes the skin is wiped clean and the reactions are measured. This test is typically done on the forearms or the back of the patient. Please wear short sleeves or sleeves that are easy to roll up past your elbow to your appointment.

- Certain medications do interfere with the allergy skin test and should be discontinued for **5 days** prior to the test. If any of these medications were prescribed, please check with your physician before stopping them. The medications to be discontinued are:

  Do not take Antihistamines: (A*llegra, Zyrtec, Xyzal, Claritan, Clarinex, Benadryl*, D*iphenhydramine* , C*hlorpheniramine, Hydroxazine) or S***teroids, Tranquilizers, Sedatives,**

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Muscle Relaxants, Ibuprofen, or Anti-inflammatory drugs (*including Motrin and Aleve,Celebrex)* **Patanase or Astelin.**

- Skin testing or allergy therapy on patients who take **Beta Blockers** must be done with caution. Please inform your doctor if you are taking a Beta Blocker prior to testing.

  Note if you are taking a Beta Blocker or Beta Blocker containing medicine, do not stop the medication without consulting with the prescribing physician. Please notify us before testing or treatment for allergies.

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INFORMED CONSENT FOR ALLERGY TESTING AND TREATMENT

(D*o not sign this form until you have read it and fully understand it's contents)*
Patients name:_____Date:_____

In addition to the requirements of Pennsylvania state law, the following consent is also intended to improve communication with the education of patients. The following has been explained:

1. The diagnosis requiring this procedure is ***Allergic Rhinitis.***
2. The nature of this procedure is ***Hyposensitization.***
3. The purpose of this procedure is to ***alleviate allergic symptoms***.
4. ***Possible risks:*** It is impossible to truly list all of the complications that may occur from any procedure. However, risks here have been carefully considered. there may be possible risks involved in this procedure including but not limited to ***skin rash, bronchial asthma, anaphylactic shock, delayed response, diarrhea, allergic reaction, headache, local arm reaction, death.***
5. The likelihood of success of this procedure is excellent.
6. The practical alternatives to this procedure include antihistamines and other medical treatments.
7. If the patient chooses not to have the above procedure, the patient's prognosis (future medical condition) is unknown.

I understand that the physician, medical personnel or other assistant will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition in recommending the procedure, which has been explained.
I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the results of this procedure.
Patient signature:_____ Date:_____

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