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| **allergylogo** | **ALLERGY & ASTHMA CARE OF FAIRFIELD COUNTY, LLC**Adult & Pediatric Allergy & Asthma55 Walls Drive • Suite 405 • Fairfield, CT 06824 • **203-259-7070** • Fax 203-254-740235 Corporate Drive • Suite 1115 • Trumbull, CT • 06611 • 203-445-1960www.allergyandasthmacare.com |

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***Kenneth Backman, MD • Katherine Bloom, MD • Sara Dever, MD***

***Suzanne Hines, APRN • Jillian Ross, APRN • Elizabeth Strong, APRN***

**Consent/Authorization Form**

**Peanut Desensitization/Oral Immunotherapy**

I understand that I have (or my child has) an allergy to peanut and that peanut allergy is a potentially life-threatening medical condition. Currently, the traditional treatment of peanut allergy consists of avoiding peanut and keeping emergency medication (epinephrine auto-injector and quick onset oral antihistamines) readily available for emergency use.

An additional treatment option known as **Peanut Desensitization/Oral Immunotherapy** has been offered and explained to me in great detail. This therapy has been done in many studies and offices throughout the United States and is FDA approved. This procedure involves the allergic individual consuming increasing doses of the food one is allergic to, in the hope of achieving a state of immunologic tolerance (desensitization). The purpose of this treatment is to decrease the likelihood that accidental ingestion of peanut would trigger a potentially life-threatening allergic reaction.

I understand that successful completion of Peanut Desensitization/Oral Immunotherapy does not mean that I am no longer allergic to peanut, and it remains essential that an epinephrine auto-injector and quick onset oral antihistamines always remain available for emergency use. **Peanut must continue to be avoided, other than for the treatment dose.**

I understand that the Peanut Desensitization/Oral Immunotherapy procedure is associated with the risk of triggering a serious, potentially life-threatening allergic reaction. Symptoms may include hives/itching/swelling, abdominal pain, swelling of the throat, difficulty breathing/speaking, decrease of blood pressure with possible loss of consciousness and anaphylactic shock. This would require emergency medical treatment and/or hospitalization.

In consideration of these risks, I agree to carefully follow my allergist’s instructions and precautions, before, during and after this procedure.

I understand that the Peanut Desensitization/Oral Immunotherapy process will take months to accomplish and that multiple office visits will be required. I agree to maintain an appropriate schedule of visits as directed by my allergist.

I understand that the Peanut Desensitization/Oral Immunotherapy process is not successful in every individual.

I agree to remain in the allergist’s office as advised by the allergist, for monitoring after peanut doses are administered in the office and to carefully monitor for possible adverse reactions after home doses.

If there have been any missed doses or I am having difficulty adhering to the prescribed treatment plan, I will notify my allergist immediately.

If I start any new blood pressure medications or have symptoms of uncontrolled asthma or allergic rhinitis (hay fever) I will notify my allergist immediately.

I understand that the desensitized state can be maintained indefinitely only as long as one continues to have constant consumption of the treatment food. If the desensitization process is interrupted or stopped, my protection from peanut allergic reaction ceases.

I have reviewed the “Peanut Desensitization: Home Dosing Instructions” and “Frequently Asked Questions” literature provided to me. I have had the opportunity to discuss this procedure at length with my Allergist and all questions have been answered to my satisfaction. I request Peanut Desensitization/Oral Immunotherapy for myself of my child.

**\_\_\_\_\_\_ I agree to pay the fee of $500, which is non-refundable, for our generic peanut protein supply** Initial **preparation and staff time. This must be paid at the first OIT visit and is not billed to insurance.**

**\_\_\_\_\_\_ I understand that my insurance will be billed for each office visit, desensitization and up** Initial **dosing visit. If** **Palforzia is used, coverage will be through my prescription plan.**

**\_\_\_\_\_\_ I understand that spirometry, if patient has asthma, will be performed at each visit and** Initial **billed to insurance.**

**I certify by my signature that I have read and understand the preceding information and that any questions I had about food desensitization have been satisfactorily answered by my allergist.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For minors:***

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Signature of parent/guardian Parent/Guardian Name (print) Date