Consent for Food Oral Immunotherapy

Patient Name: ____

Date of Birth: ____

Address: ____

For a Minor, Name of Parent/Legal Guardian:

____

Parent/Guardian Address: ____

I have been informed that the patient is allergic to _____________________ and I have discussed with my physician the possibility of treatment with oral immunotherapy to reduce my or the patient's risk of experiencing an allergic reaction to this food.

I understand that this procedure involves giving increasing doses of the food to which the patient is allergic in order to achieve a state of immunologic tolerance (desensitization).

I further understand that the oral immunotherapy procedure carries a significant risk of causing a serious allergic reaction, including hives, swelling, bronchospasm with difficulty breathing, loss of consciousness and shock, which may require emergency treatment and hospitalization. Food allergy reactions can be fatal. There is also a risk of eosinophilic esophagitis (EoE) developing. This is an inflammation of the digestive tract that can cause heartburn, food impaction (getting stuck) and may become a cronic condition requiring medication and in some cases surgery.

In consideration of these risks, I agree to carefully follow my physician's instructions and precautions before, during and after this procedure. I recognize that a key part of this procedure involves giving doses of the desensitizing food at home every day. I WILL INFORM THE STRAUSS ALLERGY AND ASTHMA DIVISION OF ALLIED PHYSICIANS GROUP IF THERE HAVE BEEN ANY MISSED DOSES OF THE FOOD FOR MORE THAN FORTY-EIGHT (48) HOURS. If the patient is a minor, I also agree to provide constant adult supervision for the patient during this procedure, whether the food is provided at Allied Physicians Group or at home. I understand that oral immunotherapy is a long process that will take months and in some cases years to accomplish and office visits every 1 to 2 weeks will be required. I agree to maintain an appropriate schedule of visits as directed by my physician.

In addition, my doctor has advised me that if the patient fails to continue consuming this food in the recommended quantities on a daily basis, the patient may lose the desensitized state and thus, an allergic reaction may occur if the food is eaten some later time, THEREFORE, I AGREE TO NOTIFY ALLIED PHYSICIANS GROUP AND MY DOCTOR IMMEDIATELY IN THE EVENT THAT THE PATIENT FORGETS OR DECIDES TO STOP THIS FOOD ON A DAILY BASIS.

Treatment may be terminated at the discretion of the physician.

The cost of the oral immunotherapy program will not be submitted to insurance and I will be responsible for the full fee of $6,000. This covers the cost of food allergy desensitization visits and phone calls over a 12-month period. Care for other medical issues such as asthma and other allergies will be submitted to insurance if applicable and I will be responsible for any copayments or deductibles. There is no guarantee of success for this program and no reimbursement for failure to complete the process.

By signing this form below, I, Parent/Guardian (and, as applicable, Child), hereby certify that:

- the nature and purposes of the treatment, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me and I understand them; and
- I have had the opportunity to ask questions and have my questions answered to my satisfaction; and
- I acknowledge that no guarantees have been made about the results that may be obtained from the treatment; and
- I hereby voluntarily consent to treatment with oral immunotherapy.

Date:________________________________ X _______________________________________

(PATIENT/PARENT/GUARDIAN)

PRINT Name: ______________________________

Date: ________________________________ X ____

(CHILD, IF OVER 12 YEARS OLD)

PRINT Name: ______________________________

Date: ________________________________ X ____

(WITNESS)

PRINT Name: _______________________________

PHYSICIAN'S STATEMENT: I hereby certify that I have explained to Parent/Guardian (and Child, if over 12 years old) the nature, purpose, benefit, risks and alternatives to the proposed treatment, have offered to answer any questions and have fully answered such questions.

Date: ______________________________ X ______________________________________

(PHYSICIAN)

PRINT Name: ______________________________

Date: ______________________________ X ______________________________________

(WITNESS)

PRINT Name: ______________________________