Allergy Testing Instructions

Welcome to our ENT/AIlergy Department. We look forward to helping you solve your allergy issues. Our physicians are fellows of the American Allergy and Otolaryngology Association (AAOA) where they received their certification in allergy. We perform testing and treatment for all environmental allergies as well as asthma and eczema. We also offer testing for food allergies. Treatment options include the modern method of Sublingual Allergy Drops (SLIT) that you can do at home. We also offer allergy shots in our office (SCIT). Please read all of the information in this packet prior to your visit and fill out all of the forms included and bring them with you to your appointment.

We look forward to your appointment on (Date):_____ (Time)_____

No Vaccines For 7 days prior to testing and 7 days after testing.

Please note that allergy testing requires a lengthy appointment and we generally schedule these relatively far in advance. Because of this we require 5 days' notice of cancelation. If you do not cancel within 5 days there may be a dee charged. If you are ill, not feeling well or your asthma has flared up please contact our office prior to your appointment. A fee will not be charged for cases of emergency.

Antihistamines: You cannot be allergy tested if you have taken antihistamines within 7 days of your test. Therefore, you must stop all antihistamines 7 days prior to your appointment. You may continue all other medications including Singulair and nasal steroid sprays such as Flonase, if they have been prescribed to you. Please consult our office with any questions 203-643-6901.

- Allergy skin testing takes approximately two hours.
- Please wear a top that is comfortable. Female patients: Please do not wear a sports bra, if you have long hair, please wear it up in a ponytail or a hair clip.
- Be sure to eat something one hour prior to your appointment. Do not change your diet prior to testing.
- No Holter Monitors are allowed during testing, if you have one, please reschedule your appointment.
- Please note that you will be asked to change into a hospital top prior to testing.
- **Asthma patients**: must bring their inhaler with you and notify nurse before testing begins if you have needed to use it this week.
- **Diabetes patients**: Please bring your glucometer, lancets and test strips to your appointment. If you are noticing increased symptoms while off your antihistamines, please call our office immediately so we can resolve them prior to testing.
- A parent or guardian must accompany children under 18 years of age throughout the entire testing process.
- Please Note the Allergy Department is located at: 11 Harrison Ave, Branford, CT 06405 Suite #1
- After testing you will be given an appointment with your provider to review your treatment options.

Any questions or concerns please feel free to call our Allergy Department in the Branford office at (203) 643-6901.

Thank you,

Dr. Paul Alberti, Allergist, M.D., FACS, FAAOADr. Agnes Czibulka, M.D. FAAOA

11 Harrison Ave. Branford. CT. 06405 | 203-643-6901 | Fax 855-357-1519

MEDICATIONS **NOT** TO TAKE PRIOR TO ALLERGY TESTING

Tvpes of Medications	Examples of Medications	Time Span to Hold
Antihistamines (HI blockers)	Accuhist, Allegra, Antivert, Anihist Astelin, Astopr, Atarax, Azelastine, Bendryl, Bonnine, Bromphen, Chor-Trimetron, Claritin, Clarinex, Clarinex, Compazine, Deconamine, Dimetapp, Dramamine, Dymista, Durahist, Elestat, Maxified, Meclizine, Optivar, Pataday, Patanase, Patanol, Pazeo, Periactin, Phenergan, Polaramine, Reglan, Tavist, Xyzal, Zaditor, Zyrtec	Hold 7 days prior
Reflux meds (H2 blocers)	Axid, Pepcid, Tagament, Zantac Prilosec, Protonix	Hold for 48 hours prior
Topical Steroids	Creams, Gels, Lotions, Ointments Minoxidil	Hold evening prior
Muscle Relaxants	Banaflex, Flexeril, Norflex, Skelaxin Zanaflex	Hold 5 days prior
Anti-inflammatories	Advil, Aleve, Aspirin, Feldene, Midol, Mobic, Motrin, Naprosyn, Pamprin, ICY Hot	Hold evening prior
Over the Counter/Herbals	Actifed, Alka-Seltzer, Allent, Allerest, Astragalus, BC Cold Powder, Cerose, Cheracol, Codimal, Comtrex, Comhist, Contact, Coricidin, Deconmaine, Demazin, Duravent, Feverfew, Green tea, Licorice, Kronofed, Milk Thistle, Naldecon, Nolahist, Novafed, Optimine, St. Johns Wart, Saw Palmetto, Sinutab, Sudafed plus, Theraflu, Triaminic, Tylenol PM, Unisom, Vics (Anything with a decongestant)	Hold 7 days prior

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IF YOU HAVE ANY QUESTIONS PLEASE CALL THE OFFICE 203-643-6901

Medication Avoidance, Beta Blockers & Increased Symptoms

Antihistamines (HI blockers) are to be held 7 days prior to testing. Antihistamines are found in pills, liquid, eye drops and nasal sprays. Please feel free to call your pharmacist with any medication questions.

v/ Examples of Medication Names: AccuHist, Allegra, Antivert, Antihist, Astelin, Astepro, Atarax, Azelastine, Benadryl, Bonine, Bromphen, Chlor-Trimeton, Claritin, Clarinex, Compazine, Deconamine, Dimetapp, Dramamine, Dymista, DuraHist, Elestat, Maxifed, Meclizine, Optivar, Pataday, Patanase, Patanol, Pazeo, Perlactin, Phenergran, Polarmine, Reglan, Tavist, Xyzal, Zaditor, Zyrtec

Please contact the office immediately if you are on a beta blocker. Beta blocker medications are generally used for heart disease, high blood pressure, irregular heartbeat, migraines, etc. Hold these Medications the day before the test.

v/ Examples of Medication Names: Acebutolol (Sectral, Monitan), Atenolol (Tenormin), Betaxolol (Kerlone), Bisoprolol (Zebeta, Monocor), Carteolol (Cartrol), Carvedilol (Coreg), Corzide, Esmolol (Brevibloc), Inderide, Inderide LA, Labetolol (Trandate, Normodyne), Lopressor HCT, Metoprolol (Lopressor, Toprol-XL, Betaloc), Nadolol (Corgard), Penbutolol (Levatol), Pindolol, Propranolol (Inderal, Innopran), Tenoretic, Timolide, Timolol (Blocadren), Ziac

Are you experiencing increased symptoms?

When you are off of your antihistamines (Claritin, Zyrtec, Patanase, Pataday, etc.) for your upcoming allergy test appointment, if you start to have increased allergy symptoms, please notify the office immediately. Also, please let us know if you need to use your rescue inhaler.

Should you have increased allergy symptoms on the day of your appointment (i.e., runny nose, congestion, coughing, etc.), we will have to reschedule your skin test.

Why? Because if you have increased symptoms, we do not want to overload your system by adding 38 other items to which you might be allergic. Doing that could possibly result in a severe allergic reaction.

So if you do start to notice increased symptoms, please notify the office immediately so that we can call in a medication for you that will help control your symptoms but won't interfere with the testing process. Once your symptoms are gone, we can proceed with your skin testing.

Thank you, and if you have additional questions, please let one of our staff assist you.

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Allergy Codes for Testing and Treatment

Most insurance plans cover allergy testing and SCIT (subcutaneous immunotherapy) injections. To verify your coverage, please contact your insurance carrier and ask the following questions.

Testing	Shots
Skin Prick Test = 95004 x 40	Serum Mixture = 95165 x 40
Intradermal Test = 95024 x38	One injection = 95115
	Two or More Shots = 95117

1) I am planning to have allergy testing performed by my doctor, and I would like to verify that my insurance plan covers the following two tests:

   a. The first is a Skin Prick Test that is billed using CPT code 95004 times 40 allergens tested. Does my plan cover this?

   - o Yes
   - o No o If not, what is covered?

   _____

   b. The second is an Intradermal Test that is billed using CPT code 95024 times 38 allergens tested. Does my plan cover this?
   o Yes o No o If not, what is covered?

   _____

2) If I find that I am allergic, then I plan to start receiving injections, and I would like to verify that my insurance plan covers the following:

   a. Serum Mixture that is billed using CPT code 95165 times 40 doses. Does my plan cover this? And how many total doses are covered per calendar year?

   - o Yes, and the total dose per calendar year is _____
   - o No o If not, what is covered? _____

   b. One injection that is billed using CPT code 95115. Does my plan cover this? o Yes
   O No o If not, what is covered?

   _____

   c. Two or More Shots that are billing used CPT code 95117. Does my plan cover this? o Yes
   o No o If not, what is covered? 3) What will my copay be for testing?

   _____

4) What will my copay be for treatment?

   _____

5) What is my total out-of-pocket expense?

   _____

6) Can you please give me your name?

   _____

SCIT (subcutaneous immunotherapy/shots) are generally 4 to 8 years of therapy.

SLIT (sublingual immunotherapy/drops) are generally 2 h to 3 years of therapy.

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Anaphylaxis Emergency Action Plan

Patient Name: _____ DOB: _____

Allergy: _____

Asthma: Yes No Other health problems: _____

Current Medications (if any):

Hospital of Choice:_____

Symptoms of Anaphylaxis Include:

Mouth = Itching, swelling of lips and/or tongue

Throat = Itching, tightness closure, hoarseness

Skin = Itching, hives, redness, swelling

Gut = Vomitting, diarrhea, cramps

Lung*= Shortness of breath, coughing wheezing

Heart* = Weak pulse, dizziness, passing out

* Can be life-threatening — act fast!

Only a few symptoms may be present. Severity of symptoms can change quickly.

What to Do:

1. Inject epinephrine into thigh using Epipen. (Important: Asthma inhaler and/or anithistamines cannot be depending on in anaphylaxis)
2. Call 911 or Rescue Squad (before calling contact below)
3. Emergency Contact:_____Relationship:_____Phone#_____
4. Emergency Contact:_____Relationship:_____Phone#_____

Do Not Hesitate to Give Epinephrine!

Patient Name:_____Date:_____

Signature: _____ Date: _____

Doctor Signature:_____Date: _____

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Medication List

Name: _____ DOB: _____Chart #:_____

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

11) _____

12) _____

13) _____

14) _____

15) _____

16) _____

17) _____

18) _____

19) _____

20)_____

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Allergy Exposure Form

Name:_____DOB:_____ Date:_____

In regards to your allergy symptoms (For example, congestion, runny nose, post nasal drip, sinus issues, Ear or eye problems). Please rate the following questions 0-10. 10 is the worst.

What is your worst allergy season and why?

Spring

When you or your neighbor cut the grass does it bother your allergy symptoms? 0 1 2 3 4 5 6 7 8 9 10

When the trees start to bloom does it bother your allergy symptoms? 0 1 2 3 4 5 6 7 8 9 10

Summer

Do you garden? If so, does it bother your allergy symptoms? 0 1 2 3 4 5 6 7 8 9 10

Does it bother you to go into the basement? 0 1 2 3 4 5 6 7 8 9 10

Winter

Does it bother you when the mold is under the leaves and the spore count goes up in the fall?

0 1 2 3 4 5 6 7 8 9 10

When the heat is on does it bother your allergy symptoms? 0 1 2 3 4 5 6 7 8 9 10

Asthma (If applicable)

What triggers your asthma and bothers your breathing the most?

Do you see a pulmonary, M.D.? If so, who?

Have you had to use your rescue inhaler? ___If yes how often:_____

What inhalers do you currently use?

Other

Do you experience increased symptoms when at work or school?

Is the building at work/school older or newer?

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Questionnaire for Allergy Testing, Injections & Vials

Please answer "yes" or "no" to all questions prior to receiving any allergy treatment. It is important that we are aware of any changes in your medications or symptoms prior to testing you. Thank you!

YES NO

YES NO

- ❑ Are you pregnant or is there a possibility
- Are you using beta blockers (medications that you might be pregnant? used for high blood pressure, heart disease, migraines, glaucoma)?
- ❑ Do you have asthma? If yes, when was your rescue inhaler?
- Are you using MAOI's or tricyclics (medications used for depression or Anxiety)? the last time you used _____
- ❑ Have you needed to use you rescue inhaler this week?
- Did you have a reaction your last treatment with us (injection, testing or vial test)?
- ❑ Are you sick today?
- If you had a reaction to your last treatment, did you notify us?
- ❑ Do you have a fever?

Please notify us what symptoms:

- ❑ Have you been placed on antibiotics since your last visit with us?
- Shortness of breath
- ❑ Swelling of the lips
- ❑ Are your sinuses bothering you more than usual today?
- Other today? _____
- ❑ Do you have any type of rash or hives today?

If yes, where? _____

- ❑ Have you had any large allergen exposure recently? (Mowing the lawn, the injection. After your attending outside sporting events, large animals, etc.)
- Remember, you must remain in office for 30 minutes after wait, please share any reactions with allergy department.
- ❑ Have you exercised or participated in any sporting activity within the past 4 hours?
- (Remember, no exercise or strenuous activities for 4 hours prior to allergy treatment nor for 4 hours after treatment?)

Name: _____

Date: _____

Any changes in your medications since your last visit with us? Please review with the nurse prior to treatment.

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Allergy Testing Instructions

The following Items Are Extremely Important (Please Read)

- Allergy skin testing takes approximately two hours to complete. o Please wear a top that is comfortable. *Female Patients: Please do not wear a sport's bra* o Be sure to eat something one hour before coming in for testing. Do not change your diet before testing. o Do not wear any perfume, perfumed lotion or cologne to your testing appointment. In general, please avoid perfumes and colognes when visiting our office, as allergy-sensitive patients can be affected by these scents.
- Please make sure the allergy staff is aware of all medications that you are taking. If you are taking a beta blocker, please notify our allergy staff one week prior to testing.
- Asthma Patients: Please bring your inhaler with you and notify the nurse before testing begins if you have needed to use it this week.
- Diabetes Patients: Please bring your glucometer, lancets and test strips to this appointment.
- Insurance: Allergy testing is covered by most insurance plans. You should contact your insurance to determine what your benefit is for allergy treatment. We have attached a worksheet titled "Allergy Codes for Testing and Treatment." This worksheet lists all codes required for you to discuss with your insurance company.
- You might experience increased symptoms that might require for you to reschedule. These increased symptoms include: increased coughing, sneezing, itching, runny nose, fever, rash hives, acute asthma, or any respiratory symptoms. The last thing we want to do is have to reschedule your testing, so if you are noticing increased symptoms, please contact our office immediately so we can resolve them prior to testing.
- A parent and/or guardian must accompany children under 18 years of age throughout the entire test. o Let us know if you have had a mastectomy one week prior to allergy testing.
- If allergy testing cannot be completed for any reason (increased symptoms, fever, coughing, sneezing, itching, hives, itchy nose, etc.) we may conduct a simple blood test to obtain baseline readings. This test is not as accurate and a full skin test will be rescheduled when your symptoms subside.
- After testing is complete, you will be given a follow-up appointment with your provider to review your test results and discuss your treatment options. The allergy staff can give your further information on these treatment options (allergy shots and allergy drops).
- Please review the allergy-testing packet in full and bring all forms signed and any requested information to your appointment.

I have read these instructions and have received my packet of information for allergy-testing protocols. I understand the above and have had all of my questions answered to my satisfaction. I understand that if these instructions are not followed, testing will not be performed.

Patient Name:_____ Signature:_____ Date:_____

Witness:_____ Signature:_____ Date:_____

:

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Consent to Allergy Evaluation, Testing, and Treatment

❑ I authorize the performance of allergy evaluation, testing, and treatment upon (print first and last name)

_____

To begin on: Date: _____Time: _____Place: 11 Harrison Ave, Branford Suite 1

Under the direction of: Dr. Paul Alberti/Dr. Agnes Czibulka

I consent to:

A. The testing procedures and treatment.

B. Such procedures and treatment in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, as the above-named doctor or his/her associates or assistants may consider necessary or advisable in the course of the testing and treatment procedures. C. The administration of such medications as may be considered necessary or advisable by the doctor, associates, or assistants responsible for this service.

D. The admittances of observers to the room for the purpose of advancing medical education.

❑ I have had explained to me the nature of all testing and treatment procedures, possible alternative methods of treatment, the risk involved with this treatment, and the possibility of complications, such as localized swelling, irritation, and itching at the injection site. I may also experience an increase in my allergic symptoms, generalized (whole body) hives and swelling, difficulty breathing, anaphylactic shock, and possible death. No guarantee or assurance has been given by anyone as to the results that may be obtained.

❑ I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient to give this informed consent.

❑ I certify that I have read and fully understand the above consent to allergy testing and treatment thereof, that the explanations therein referred to were made, that all the blanks and statements requiring insertion or completion have been filled in, and that inapplicable paragraphs, if any, were stricken before signed.

❑ I am responsible for the payment of this procedure.

Patient Signature: _____ Date:_____

❑ The foregoing consent was read, discussed and signed in my presence, and in my opinion, the person(s) signing did so freely with full knowledge and understanding.

Witness Signature_____Date:_____

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SINO-NASAL PRE-SCREENING TEST (SNOT 22)

Patient Name: _____ Date: _____

DO YOU HAVE A SENSE OF SMELL: YES _____ NO _____ TASTE: YES_____ NO _____

Consider how severe the problem is, how frequently it happens and rate those problems (**based on the last two weeks**)	No problem	Very mild problem	Slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be
Need to blow your nose	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Runny nose	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Post nasal discharge	0	1	2	3	4	5
Thick nasal discharge	0	1	2	3	4	5
Ear fullness	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Ear pain/pressure	0	1	2	3	4	5
Facial pain/pressure	0	1	2	3	4	5
Difficulty falling asleep	0	1	2	3	4	5
Waking up at night	0	1	2	3	4	5
Lack of a good night sleep	0	1	2	3	4	5
Waking up tired	0	1	2	3	4	5
Fatigue during the day	0	1	2	3	4	5
Reduced productivity	0	1	2	3	4	5
Reduced concentration	0	1	2	3	4	5
Frustrated/restless/irritable	0	1	2	3	4	5
Sad	0	1	2	3	4	5
Embarrassed	0	1	2	3	4	5
Sense of smell/test	0	1	2	3	4	5
Blockage/congestion of nose	0	1	2	3	4	5
Headache	0	1	2	3	4	5
TOTAL EACH COLUMN						

Grand Total_____

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YES	NO	
❑	❑	When I walk or do simple chores, I have trouble breathing or I cough.
❑	❑	When I perform heavier work, such as walking up hills and stairs or doing chores that involve lifting, I have trouble breathing or I cough.
❑	❑	Sometimes I avoid exercising or taking part in sports like jogging, swimming, tennis, or aerobics because I have trouble breathing or I cough.
❑	❑	I have been unable to sleep through the night without coughing attacks or shortness of breath.
❑	❑	Sometimes I make wheezing sounds in my chest.
❑	❑	Sometimes my chest feels tight.
❑	❑	Sometimes I cough a lot.
❑	❑	Dust, pollen, and pets make my breathing more difficult.
❑	❑	Cold weather makes my breathing more difficult.
❑	❑	My breathing problem gets worse when I'm around tobacco smoke, fumes, or strong odors.
❑	❑	When I catch a cold, it often goes to my chest.
❑	❑	I made one or more emergency visits to a doctor in the past year because of my breathing problems.
❑	❑	I have had one or more overnight hospitalizations due to breathing problems in the past year.

YES	NO	
❑	❑	I feel like I use my asthma inhaler too often.
❑	❑	Sometimes I don't like the way my asthma medicine makes me feel.
❑	❑	My asthma medicine doesn’t control my asthma.
❑	❑	My asthma controls my life more than I would like.
❑	❑	I feel tension or stress because of my asthma.
❑	❑	I worry that my asthma affects my health or may even shorten my life.
❑	❑	Do you react to animals?

If you answered "yes" to one or more of the Asthma Check questions, you may be letting asthma stop you from having fun and feeling good.

Taking better care of your allergies will help you gain better control of your asthma. Ask youd doctor about how asthma may be affecting your quality of life.

ASTHMA LIFE QUALITY TEST

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