Patient Name: _____ Date of Birth: _____ Date: _____

Medical Qualification Form

***Provider Section only**

Was an ENT Completed? ☐YES ☐NO Is patient taking Beta Blockers? ☐YES ☐NO

Diagnosis: ☐ Allergic Rhinitis, unspecified (J30.9) ☐ Other allergic rhinitis (J30.89) ☐ Allergic rhinitis due to pollen (J.30.1) ☐ Allergic rhinitis due to animal (cat) (dog) hair and dander (J30.81) ☐ Other seasonal allergic rhinitis (J30.2) ☐ Allergic Rhinitis (w) Mild Intermittent Asthma (J45.20, J45.901) ☐ Other: _____

Asthma exacerbations associated with allergic rhinitis: ☐YES ☐NO
History of 2 or more seasons of allergy symptoms: ☐YES ☐NO Test for allergies: ☐YES ☐NO

The patient has had an inadequate response to standard medical management interventions. I suspect given the patient's history the symptoms appear to be environmental in nature and thus, the airborne panel of molds, pollen and danders are appropriate given this strong correlation. ☐YES ☐NO

Provider's Notes: _____

_____

Provider Signature: _____ Date: _____

Provider Name: (Printed): ☐ Rajan Kapoor, M.D. ☐ Rajnish Puri, D.O.

***Patient Section**

Are you currently taking any Blood Pressure Medication? ☐YES ☐NO
If yes, please list: _____

Do you have a history of Cardiovascular Disease/Disorders? ☐YES ☐NO
If yes, please list: _____

Do you have a history of any Immune System Disorders? (Ex: Cancer, HIV, etc) ☐YES ☐NO

Have you ever had an anaphylactic reaction requiring emergency medical attention or use of an epi-pen? ☐YES ☐NO

Do you use an inhaler for asthma three or more times a day? ☐YES ☐NO

Do you have a history of respiratory disease other than asthma? (Ex: COPD) ☐YES ☐NO

Within the past year have you had an allergy scratch test? ☐YES ☐NO

Do you have a history of taking any allergy medications including allergy shots? ☐YES ☐NO
If yes, please list: _____Last Used: _____
Do you have a history of taking any steroids? (Oral, inhaled, or topical) ☐YES ☐NO
If yes, please list: _____Last Used: _____
Are you pregnant? ☐YES ☐NO

***If there is any possibility that you are pregnant, please notify the provider before you have the allergy test.**

Patient's Signature: _____ Date: _____/_____/_____

Patient ID# (Staff use only): **FL1742.____**

Patient Name: _____ Date of Birth: _____ Date: _____

Quality of Life and Wellness Questionnaire

Contact Information: Home (_____) _____-_____ Cell (_____) _____-_____

Do you suffer from allergy symptoms? Yes _____ No _____

1. Is your quality of life affected by your allergy symptoms? ____No ____Mildly ____Moderately ____Considerably

2. Are you currently or have you in the last 12 months taken any prescription or over-the counter antihistamine medications to alleviate your allergy symptoms? (Ex: Claritin, Allegra, Zyrtec, Singulair, Benadryl....) Yes_____ No_____

If yes, list the medications:_____

3. Are you currently or have you in the last 12 months taken any prescription or over-the counter steroidal medications to alleviate your nasal symptoms or hay fever? (Ex: Flonase, Prednisone, Cortisone, Nasacort…) Yes_____ No _____

If yes, list the medications:_____

4. Are you currently or have you in the last 12 months taken any prescription or over-the counter inhaled medications to alleviate asthma symptoms? (Ex: Pulmicort, Flovent, Symbicort, Advair, Albuterol....) Yes_____ No_____

If yes, list the medications:_____

Please complete the following questionnaire by indicating a number between 0 and 10 where 0 is never, and 10 is often.	0.Never	→	10.Often
1.) Stuffy Nose	0.Never	____	10.Often
2.) Runny Nose	0.Never	____	10.Often
3.) Itchy Eyes	0.Never	____	10.Often
4.) Watery Eyes	0.Never	____	10.Often
5.) Itchy Throat	0.Never	____	10.Often

Please complete the following questionnaire by indicating a number between 0 and 10 where 0 is never, and 10 is often.	0.Never	→	10.Often
1.) How often do you rely on medications for relief?	0. Never	____	10. Often
2.) How often are you affected by allergy symptoms?	0. Never	____	10. Often
3.) Have you missed work as a result of allergy symptoms?	0. Never	____	10. Often
4.) Have you had your home life interrupted by allergy symptoms?	0. Never	____	10. Often
5.) Have you suffered a loss of sleep from allergy symptoms?	0. Never	____	10. Often
6.) Have others been impacted by your allergies?	0. Never	____	10. Often

7.) Do you suffer from headaches and/or migraines? Yes_____ No_____

8.) Do you suffer from chronic skin irritation? Yes_____ No_____

9.) Do you suffer from depression/mood swings? Yes_____ No_____

10.) Do you have trouble sleeping and/or fatigue? Yes_____ No_____

11.) Do you suffer from chronic congestion? Yes_____ No_____

I have had an inadequate response to standard medical management interventions. Yes _____ No _____

Patient Signature: _____ Date: _____/_____/_____

Patient ID# (Staff use only): **FL1742.____**

Patient Name: _____ Date of Birth: _____ Date: _____

INFORMED CONSENT FOR ALLERGY TESTING WITH IMMUNOTHERAPY EDUCATION

The following consent is intended to improve communication with and education of patient's. The following has been explained:

1. The diagnosis required for this procedure: **Allergic Rhinitis and/or similar diagnosis.**

2. The nature of this procedure is: **Hypo-sensitization** – an attempt to reduce sensitivity to what you are allergic to. The procedure also includes testing of the skin for allergic reactions with a 10 pronged skin prick device.

3. The purpose of these procedures is: **to test for allergies and help relieve allergy 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 these procedures including, but not limited to:
   - **Local reactions:** Burning, itching, bleeding, swelling, hives, redness of skin, skin blistering/sloughing, and/or possible infection at the injection/test site.
   - **Mild systemic reactions:** Nasal congestion, runny nose, skin rash, diarrhea, headache, itching of ears, nose, throat, sneezing and/or itchy, watery eyes.
   - **More severe reactions:** Wheezing, coughing, shortness of breath, swelling of tissue around eyes, tongue or throat, stomach or uterine cramps, and possible miscarriage.
   - **Rare complications:** Abnormalities of the heartbeat, delayed response, loss of ability to maintain blood pressure and pulse, anaphylactic shock and death.
   - **Severe:** There is the possibility of severe reactions involving the heart, lungs, and blood vessels which, if unrecognized and untreated, could be fatal.

5. **Precautions to be taken**: There is a possibility of a reaction occurring after a patient who received their injection(s) or skin testing leaves our office. It is vitally important that any such reaction be reported to the physician before receiving the next injection. If you are ever concerned about a reaction you have after leaving our office, you should return to our office or go to your local emergency room or immediate care facility for treatment.
   IF YOU ARE EXPERIENCING A LIFE-THREATENING EMERGENCY, IMMEDIATELY CALL 911!

6. **Duration of Treatment**: The average patient will be on allergy Immunotherapy for a minimum of 1 year. This schedule is impossible to predict and will differ from patient to patient depending on what your allergies are, the severity, and how you tolerate treatment. Your treatment with Immunotherapy will be more successful and pose less risk if you are consistent with your allergy shots according to your dosage log, which will be communicated to you by the Clinical Laboratory Specialist.
   Note: If you are not consistent with your allergy injections, you not only decrease the success of your treatment but also increase your risk of having adverse reaction(s) to your Immunotherapy, including the risk of anaphylactic shock. If you cannot be consistent with your allergy injections and appointments, you will be asked, for your own protection, to consider alternative forms of allergy treatment. A repeat offender who is unable to follow their injection schedule may be prevented from receiving allergy shots and their treatment may be discontinued at the discretion of the physician and/or allergy department.

Patient ID# (Staff use only): **FL1742.____**

Patient Name: _____ Date of Birth: _____ Date: _____

7. Immunotherapy treatment has up to an **85% success rate**.

8. The **practical alternatives** to these procedures include antihistamines and other medical treatments.

9. **Prognosis**: If the patient chooses not to have the above procedures, 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 procedures or the course of treatment for the patient's condition in recommending the procedures, 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 these procedures.

I understand that during the course of the procedures described above it may be necessary or appropriate to perform additional procedures, which is unforeseen, or not known to be needed at the time this consent is given. I consent to and authorize the person described herein to make the decision concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

I consent to the presence of observers in the allergy lab for medical, scientific or educational purposes approved by my physician. I consent to the taking and publication of any photographs or video taken during the course of the patient's procedure for medical, scientific or education purposes approved by my physician.

By signing this form, I acknowledge that I have read or had this form read or explained to me and that I fully understand its contents. I have been given the opportunity to ask questions and all of my questions have been answered satisfactorily. I have also received additional information including but not limited to the materials listed below, related to the procedure(s) described herein.

I am aware that taking beta-blockers can greatly increase the risk of severe reactions, asthma and possible death during allergy Immunotherapy and skin testing. If at any time I begin taking beta-blockers, develop a heart arrhythmia or if I have uncontrolled hypertension (high blood pressure), I agree to inform the allergy lab technician and the physician that recommended Immunotherapy.

Female Patients: I agree to notify my physician and the allergy lab technician immediately upon learning that I have become pregnant during the course of allergy Immunotherapy treatment.

I consent to allow **Dr. Kapoor/University Medical Care, P.A.** and all medical personnel under the supervision and control of such physicians and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

Patient Name: _____ Date of Birth: _____ Date: _____

1. I understand the above Informed Consent document. ☐Yes ☐No

2. I understand the nature, expected benefits and risks of the above described testing/treatment procedures as well as alternative treatment options. ☐Yes ☐No

3. I understand there are no guarantees to the testing and/or treatment outcomes. ☐Yes ☐No

4. I understand a parent or guardian must be present in order for a patient under the age of 18 to receive a consultation and/or treatment of any kind. ☐Yes ☐No

5. I understand all patients who receive injections must remain in the office for observation for no less than 20 minutes after their injection(s), until checked by an allergy lab technician and that anyone leaving prior to this time does so against medical advice and thus accepts all liability for subsequent reaction(s). ☐Yes ☐No

6. I understand if I have any reaction(s) to the allergy injections and/or skin prick testing procedure, I am responsible for reporting these reactions in a timely manner to the allergy department and if I am concerned about reaction(s), I will return to the allergy department or go to the local emergency room or immediate care facility for treatment. ☐Yes ☐No

7. I understand if I am unable to be consistent in following my allergy injection schedule according to my dosage log, this increases my risk of having an adverse reaction to Immunotherapy. ☐Yes ☐No

8. I understand that if I repeatedly fail to be consistent with my allergy injection schedule according to my dosage log, my Immunotherapy treatment may be discontinued by your office for my own safety. ☐Yes ☐No

I, the undersigned, have read all three (3) pages of this form in its entirety and/or have had this form explained to me and fully understand the contents of this authorization.
I consent to airborne allergy testing under the supervision of Dr. Kapoor/University Medical Care, P.A. Upon receipt of my allergy skin test results my physician may prescribe Immunotherapy Treatment.

Patient's Signature/Legal Authority: _____ Date: _____

Relationship to patient: _____

Witness: _____ Date: _____

Patient ID# (Staff use only): **FL1742.____**

Patient Name: _____ Date of Birth: _____ Date: _____

ALLERGY INSURANCE ACKNOWLEDGEMENT FORM

Supervising Physician: **Dr. Rajan Kapoor**

Dear Allergy Patient:
Based upon your doctor's recommendation, you have consented to Airborne and/or Food Allergy Testing. This will consist of the following:

- Airborne Allergy Scratch Test (95004)
  and/or
- Antigen Therapy Preparation (95165)
  and/or

Dependent upon your insurance company and their requirement for your doctor to receive payment, the Antigen Therapy Preparation (95165) will be billed over the course of several additional days even though you are not present at the doctor's office.

Please understand that you, the patient, cannot be present during the preparation of the antigen therapy.
If you have any questions or concerns, please contact **Dr. Kapoor/University Medical Care, P.A.** @ 407-678-5656

Patient/Guardian Signature: _____ Date: _____/_____/_____

Patient ID# (Staff use only): **FL1742.____**

Patient Name: _____ Date of Birth: _____ Date: _____

ALLERGY TESTING AND IMMUNOTHERAPY LETTER OF MEDICAL NECESSITY

Date scheduled for pick up: _____/_____/_____

Based on the results of my allergy test, I can benefit from Immunotherapy. It has been indicated as a benefit of my medical insurance and I request that my Immunotherapy Medication be made. I would be unable to come to the office several times a week over the period of a year and understand the risks and benefits associated with Immunotherapy administered outside my physician's medical office. Additionally, I wish to reduce the long-term use of allergy medications through immunotherapy.

Patient/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

- Patient has accepted Immunotherapy treatments and authorized Allergy Lab Medical Assistant to mix Immunotherapy under your supervision ☐YES ☐NO
- An ENT exam has been performed ☐YES ☐NO
- Patient's Allergy History was taken and is on file in patient's records ☐YES ☐NO
- Patient response to avoidance or pharmacological therapy has been unsatisfactory. ☐YES ☐NO
- Patient has tried OTC/RX allergy medications over the last year and did not adequately control symptoms. ☐YES ☐NO
- Patient has been informed about risks of Immunotherapy ☐YES ☐NO
- Patient has agreed to allergy testing ☐YES ☐NO
- Allergy test was valid and identified multiple allergies ☐YES ☐NO
- Based on an Individual Assessment of Patient, the benefit of Immunotherapy clearly outweighs the risk of withholding Immunotherapy, for administration outside the medical office. ☐YES ☐NO

I certify the statements above are true and correct:

Provider Signature: _____ Date: _____/_____/_____

Patient ID# (Staff use only): **FL1742.____**