CONSENT FOR VENOM IMMUNOTHERAPY

Legal name of patient undergoing immunotherapy:

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David Mangold has explained to me the procedure involved in the administration of immunotherapy (allergy injections) in a way that I understand.

1. In national studies, for venomous insect immunotherapy, improvement is 95%.
2. There may be alternative methods of treatment, which may or may not be used to control my symptoms. I understand that immunotherapy is not the only treatment available.
3. There are risks involved with immunotherapy and they have been explained to me fully. Ordinarily, local arm swelling and itching are expected after some injections. Rarely, a systemic reaction happens after an injection. Symptoms of such a reaction occur shortly after the injection and may include the following:
    a. Upper Respiratory (nasal congestion, itchy eyes, sneezing, etc.)
    b. Lower Respiratory (wheezing, coughing, short of breath, etc.)
    c. Skin (rash, hives, itching, etc.)
    d. Swelling (eyes, lips, tongue, throat, etc.)
    e. Anaphylaxis (shock, respiratory failure, death)
4. Because of these risks, I agree to wait in the office for 30 minutes after each injection or call 911 or proceed to the emergency room if any symptoms occur after I have left.
5. The costs of injections may vary depending on where you receive them and how many venoms you are receiving treatment for. The injection costs can be as high at $202. The initial treatment sets can cost as much as $1280; refill treatment sets can cost as much as $800.
6. Follow-up patient visits should be made ideally at 3 & 12 months after starting injections. A close provider-patient relationship is recommended so that vaccine adjustment can be made to assure the optimal safety and effectiveness of your immunotherapy.

If immunotherapy is for a child, a parent or guardian's signature is required. Parents or guardians are responsible for informing the staff of how each previous injection was tolerated. I am satisfied with the explanation that has been given and do not desire any more information. I give permission and consent for this treatment.

Signature of patient, parent, or guardian: ________________________ Date: ____________

Printed name of person giving consent: ________________________