



CONSENT FOR DRUG CHALLENGE

A. CONSENT FOR PROCEDURE

1. I authorize Dr. _____ to perform the following procedure(s):
Oral, intravenous, or subcutaneous drug challenge. This involves administration of a medication which you may be potentially allergic to in a slow, graded fashion under medical supervision.

I understand that other qualified practitioners, including residents (doctors who have finished medical school and are getting more training), may be chosen to do or help with procedures. All qualified practitioners will only perform tasks for which they have been granted clinical privileges or permission to practice based upon demonstrated competency. *Your attending physician will be present during key parts of the procedure but may not be present for the entire procedure. Prior to the procedure, he/she will discuss with you the roles of the members of the team and the key parts of the procedure for which he/she will be present.*

2. I understand my diagnosis/condition to be: History of allergy to _____
3. I have been told about what results to expect, which includes information about the chances for the expected results and about problems that might occur during recuperation. I know that results cannot be guaranteed.
4. I have been told about and understand the risks and benefits of the procedure(s) listed above and required positioning. I understand that there are risks for all kinds of procedures. These risks and symptoms include, but are not limited to: an itchy skin rash, nausea, abdominal discomfort, vomiting, diarrhea, stuffy "runny" nose, sneezing or wheezing. The discomforts associated with the drug challenge are generally no more than what is encountered when taking the medication. Symptoms usually are short-lived (most often less than 2 hours).

The major risks involved include severe breathing difficulties and rarely a drop in blood pressure. The risk of death is also possible but rare. The risk of a reaction is reduced by starting the challenge with a small amount of the medication followed by an observation period before further administration. You will be observed for symptoms such as itching, rash, abdominal pain, or difficulty breathing. If any symptoms develop, you will be treated immediately. In most cases, this will involve the use of diphenhydramine, non-sedating second generation oral anti-histamine, ranitidine, albuterol, or epinephrine to prevent any allergic reactions from getting worse. Very rarely, other treatments are needed for more serious reactions. Medications, personnel and equipment will be immediately available to treat allergic reactions should they occur.

In some cases, your doctor may decide to place an IV in your arm before the challenge starts. This would be used to give medicine if needed.

5. I understand the alternatives to the proposed procedure and the related risks to be: Continue to avoid the medication.
6. I understand that for some kinds of medical equipment used during procedures, a representative from the equipment manufacturer may be present, providing consultation or performing checks on the equipment.
7. I understand that photographs and/or video or electronic recordings may occur during my procedure and may be used for internal performance improvement or educational purposes.
8. I understand that any tissues or parts removed during my procedure may be disposed of by the hospital or used for any lawful purpose including education and research.

9. Consent for Serial Procedures (when applicable)

(CONTINUED ON NEXT PAGE)



0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

B. CONSENT FOR ANESTHESIA OR SEDATION**1. When local anesthesia and/or sedation is used by the physician on page one, Section A1:**

I consent to the administration of such **local anesthetics** as may be considered necessary by the physician in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures.

I consent to the administration of **sedative medications** by or under the direction of the physician named in Item A1 or the physician in charge of my sedation care. I acknowledge that I have been informed of the nature of the planned sedation and that I understand the risks of sedation to include: allergic reactions to medications, changes in breathing, changes in blood pressure and heart function, nausea and vomiting, aspiration of stomach contents and/or excitement. I understand that recall of the procedure is possible.

2. When regional anesthesia, general anesthesia, or monitored anesthesia care is provided by the personnel in the Department of Anesthesiology:

I consent to care provided by the physicians of the Department of Anesthesiology. I acknowledge that the anesthesia may actually be administered by a physician in training (resident) or nurse anesthetist under the direction of the anesthesiologist who is assigned to care for me. The anesthetic technique may be a general anesthetic ("being put to sleep") and/or a nerve block. I understand that the risks of anesthesia include: sore throat and hoarseness, nausea and vomiting, aspiration of stomach contents, muscle soreness, injury to the eyes, injury to the gums or lips, damage to the teeth or dental work, allergic reactions to medications, recall of procedure, changes in breathing, changes in blood pressure and heart function, nerve injury, cardiac arrest, brain damage, paralysis, or death.

Additional information regarding the various forms of anesthesia and pain control, risks, and options is available from the anesthesiologist directing your care.

C. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

PRINTED NAME

DATE

TIME

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Agent Named in Advance Directive☐ 4. Adult Child☐ 7. Other Blood Relative☐ 2. Guardian☐ 5. Parent☐ 8. Other* _____☐ 3. Husband/Wife☐ 6. Adult Brother/Sister

FOR MINOR PATIENTS:

☐ 1. Parents☐ 2. Guardian or Legal Custodian☐ 3. Authorized person for child in out-of-home placement

* Requires review and appointment by Ethics Consult Service. See Medical Center Policy 024, Informed Consent.

D. PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT

PRINTED NAME

PIC #

DATE

TIME

SIGNATURE OF WITNESS (OPTIONAL)
REQUIRED FOR TELEPHONE CONSENTS

PRINTED NAME

DATE

TIME

E. INTERPRETER ATTESTATION:

Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID #

PRINTED NAME

DATE

TIME