

# Next Century Medical Care

## SUBLINGUAL ALLERGEN IMMUNOTHERAPY PATIENT CONSENT FORM

Sublingual immunotherapy (SLIT) is an allergy tablet or liquid given under the tongue. SLIT should be taken under the care of a healthcare provider trained to prescribe the medication and to treat any possible reactions. The first dose is given at the medical office and, if the initial dosing is well tolerated, subsequent daily doses are administered at home. **For the first week or so, it is not uncommon for you to experience some local reactions in your mouth consisting of minor itchiness or discomfort.** These symptoms, should they occur, are typically brief and go away without any special treatment. Some individuals experience mild abdominal discomfort in the first days of treatment. Occasional serious reactions have been reported that may require immediate treatment. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, ears or throat; stuffy nose; sneezing; runny nose; mouth, nose or abdominal discomfort; coughing; swelling of the lips, tongue or throat; difficulty breathing; nausea and vomiting; hives; itching all over your body; and very rarely, a life-threatening systemic reaction known as anaphylaxis. Severe reactions, even though very unusual, may rarely occur at any time during SLIT therapy. Because of the risk of a severe reaction, **you must agree to have 2 epinephrine auto-injectors on hand with each dose of SLIT treatment.**

For the initial dosing, you are required to wait in the prescribing medical office for at least 30 minutes after administration of the tablet or liquid. If you are 17 years of age or younger, a parent or legal guardian must be present during the waiting period.

*I have read (if new patient) or re-read (if established patient) the patient information sheet on sublingual tablet allergen immunotherapy and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of sublingual tablet or liquid immunotherapy and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against possible reactions associated with this treatment. I also agree that if I have an allergic reaction to the sublingual tablet or liquid, I will follow the anaphylaxis action plan I was given.*

*I acknowledge that I am aware of the risks/benefits/alternatives to sublingual tablet or liquid immunotherapy and consent/agree to starting this treatment.*

PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

PARENT or LEGAL GUARDIAN: \_\_\_\_\_

DATE: \_\_\_\_\_

**As parent or legal guardian, I understand that I must accompany my child throughout the entire 30-minute wait.**

WITNESS: \_\_\_\_\_

DATE: \_\_\_\_\_