

HEAD AND NECK SURGERY ASSOCIATES, P.S.C.

PATIENT INFORMATION CHECK LIST

I understand all the information and instructions given to me by the Allergy Technician.

Your vaccine will be ready _____

Be sure to call the office to make certain the vaccine is ready and a doctor is present in the office before arriving for the injection.

- _____ 1. Injection hours were fully explained to me. (1st 6 weeks between 1-4:30pm)
- _____ 2. I understand when I should/should not receive allergy injections.
If I have a fever, chest cold, flu like symptoms, hives, rash or an injection from another doctor, I should not receive an injection.
- _____ 3. I was told why it is necessary to have a doctor in the office and I must wait 20 minutes after my allergy injections.
- _____ 4. I was told about possible reactions and what to do if I have one.
- _____ 5. I understand I have to wait five (5) days between allergy injections, and no more than ten (10) days to be advanced until a maintenance dose is reached.
- _____ 6. I was given a list of allergens that I was tested for and will be treated with.
- _____ 7. I was given a packet containing office policies, reaction information, avoidance control and definitions of allergens.
- _____ 8. I was advised that after testing I should follow up with my physician in two-to-three months or as directed by my physician.
- _____ 9. I have been informed about what to expect from my allergy treatment.
- _____ 10. I have informed the allergy technician of any medications I am currently taking and will let them know of any changes of medication while I am on allergy treatment.
- _____ 11. I was advised after reaching a maintenance dose and going through a thorough training, I would be able to take my vaccine home with me, as long as I have not been diagnosed with asthma, emphysema or chronic obstructive pulmonary disease.
- _____ 12. I have been advised of my estimated insurance coverage for my allergy treatment and understand that any co-pay is due at the time of service.
- _____ 13. Are you seeing a Cardiologist or being treated for High Blood Pressure or Heart Disease?
Dr. Name _____ Phone # _____
- _____ 14. I was given the chance to ask any questions, and am satisfied with the information given to me.
- _____ 15. I would like my vials mixed and understand I will be able to start injections in 2 weeks.

PATIENT OR LEGAL GUARDIAN: _____
(Signature) DATE

TECHNICIAN: _____
(Signature) DATE