Lake Norman
Ears, Nose & Throat
Piedmont HealthCare

Consent for Allergy Testing/Treatment

Patient's Name:_____ Date:_____

I hereby give permission to Fred New, APRN, BC and any assistants or associates, as he may choose, to perform allergy skin testing.

I also give permission to do any other operation(s) or procedure(s) during the specified procedure that in his judgment are necessary.

Generalized allergic reactions after skin testing unusual and very rare, but their possible occurrence should be noted.

A local reaction (at the injection site) may appear as redness, itching, or localized swelling.

A moderate to severe reaction may include (but is not limited to) difficulty breathing, wheezing, feeling of throat closing, coughing, tongue and or lip swelling, skin flushing or redness, hives or generalized itching, anxiety, rapid or weak pulse rate, confusion, blue skin around the fingernails or mouth, nausea or vomiting, and chest pain.

The nature, purpose, and possible complications of the procedure(s), the risks and benefits reasonable to be expected, and the alternative methods of treatment have been explained to me. I understand the explanations I have received, including my right to refuse such testing/treatment. My questions associated with the risk, benefit, and alternative methods of treatment have been answered.

I have read and understand the contents of each paragraph above. I acknowledge that I have received no warranties or guarantees with respect to the benefit to be realized from, or the consequences of, the aforementioned test/treatment. I further acknowledge that the time of signing this consent to testing/treatment, I was not under the influence of any drugs or alcoholic beverages.

_____
PATIENT/PARENT/GUARDIAN/CONSERVATOR

_____ _____
PERSON OBTAINING CONSENT WITNESS