

**Consent for Allergen Patch Testing**

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

I understand that I will be undergoing allergy skin testing for food allergies- the T.R.U.E. test (Allergen Patch Test). The method of testing has been reviewed with me and I understand the purpose of and need for this testing. I understand that patches will be applied and are to remain in place for 48 hours. I understand that I am to return to the office to have the results of my patch testing read on 2 different days following the application. I have been instructed on proper care for the patches, including keeping them dry, avoiding excessive sweating, and avoiding sun exposure. I understand that extreme care must be taken when showering and bathing in order to maintain dryness of the test area. I have reviewed and understand the medical precautions and handouts that I received prior to testing. I have a follow-up appointment scheduled with Dr. Gergits or Kayleigh Parks, PA-C for review of completed testing.

I understand that no testing is without risk. Allergic reactions from the testing injections are anticipated. Itching and burning sensations are common reactions to the allergenic extracts and may be severe in extremely sensitive patients. I understand that dermatitis flare-ups may occur during testing. I have been informed that should I have a severe reaction to the patches, they will be removed before the 48 hours has elapsed. I understand that if I should experience any of the following symptoms, I will let the Allergy Testing Technologist know *immediately*:

- A tingling sensation or an itch in the throat
- Sweating or dizziness
- Sensation of a lump in the throat
- General feeling of ill-ease
- Tightness in the chest
- Wheezing

I understand that allergy testing is a method developed to test patients by administering actual specific allergens. I confirm that to the best of my knowledge, I do not have an immunodeficiency, a problem with my immune status, or severe asthma.

I have been warned of the potential discomfort of allergy skin testing and the possible side effects. I have been informed of and understand the testing process and give my consent to undergo this testing.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If patient is under 18, parent/guardian must sign.)

Technician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Lynn Martz, R.N./Linda Williams)

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