DESERT CITIES ALLERGY/OTOLARYNGOLOGY

Majid Torabi, M.D., F.A.C.S.
39000 Bob Hope Dr. Probst 202
Rancho Mirage, CA 92270

I authorize the performance upon _____, of the following procedure: ALLERGY SKIN TESTING/IMMUNOTHERAPY under the direction of MAJID TORABI, M.D., F.A.C.S. I understand that some dicomfort is to be expected during the treatment procedure and that local skin reaction and generalized reactions to the treatment materials may result. The nature and purpose of this procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. No guarantee or assurance has been given to me by anyone as to the results that may be obtained.

I consent to the admittance of observers in the room to further medical education and to provide for updating my (of the patient's) madical record.

If your blood contains antibodies to the Human Immunodeficency Virus (HIV) or if you have active Acquired Immune Deficiency Syndrome (AIDS) you SHOULD NOT receive allergy injections. Immunotherapy may activate or worsen any immune deficency state. You are responsible for notifying us if an immune deficency state exists. By signing below, you indicate that you understand the risks associated with allergy therapy and do not have a known immune deficency state.

Possible reactions the day of the testing:
Redness, Itchiness, swelling of the site (arm where injection was done) and the site can continue to swell for up to 72 hours. You may have a slight fever but should not be more than 101°F.

Once the reaction size has been noted into chart, the site of testing will be cleaned off with alcohol and a hydrocortisone cream will be applied to arm to help with any itchiness and redness, we do recommend that the patient take an allergy medication (Allergra, Zyrtec, Claritin, etc.) as soon as you return home to minimize any other possible allergic reactions that can occur.

Has patient taken any allergy/antihistamine in last 2 weeks? _____
Has patient taken any nasal spray in last 3 days? _____
Has patient ever had history of antiphalactic shock? _____
Is patient on any antidepressant medication _____
Is patient on any blood pressure medication? _____

Signature of patient (orguardian if patient is a minor): _____

Date: _____