

## INFORMED CONSENT FOR RUSH IMMUNOTHERAPY (ADULTS)

My physician, Dr. \_\_\_\_\_, has recommended a rapidly advancing course of allergy shots (known as RUSH IMMUNOTHERAPY) instead of the usual allergy shot schedule for the following reasons (check all that apply):

- History of asthma or previous allergy shot reactions preventing successful desensitization
- Time or distance constraints preventing more than 6 months of weekly visits to this office
- Desire for more rapid improvement in allergy symptoms

I have read and understand fully the attached ***Information and Instructions For Patients Receiving Allergen Immunotherapy*** and ***Instructions for Patients Prior to Rush Immunotherapy***. I understand that this rush procedure will replace the usual escalation phase of conventional allergy shot therapy. **I understand that there is approximately a 25% risk of a generalized allergic reaction with this procedure (including hives, itching, sneezing, wheezing, difficulty breathing, vomiting, diarrhea and shock), which may require treatment in the office and possibly hospitalization. In consideration of these risks, I agree to follow all precautionary measures as I have been instructed.** I further understand that, in the event of a generalized allergic reaction, this procedure will be terminated for safety reasons. In this event, the decision of whether or not to resume allergy shots according to a modified schedule will be made jointly with my physician.

I have had the opportunity to ask additional questions regarding the anticipated benefits and potential risks of rush allergen immunotherapy. These questions have been answered to my satisfaction.

I hereby give consent to receive immunotherapy injections (allergy shots) according to rush protocol and authorize treatment of any reactions that may occur as a result of this procedure.

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name / Signature

\_\_\_\_\_  
Date