NORTHSIDE ENT INC.
EAR, NOSE, AND THROAT SPECIALISTS

Your appointment for Allergy Skin Testing is on:

Date: ________________________ Time: _______________________________

This testing time has been set aside for you. Please give 24-hour notice for cancellation. We reserve the right to bill you for failed appointments.

12065 Old Meridian Street, Suite 205

Carmel, IN 46032

(317) 844-5656

Your follow up appointment is scheduled with Dr. _________________________

Date: ________________________ Time: ______________________________

Dear Northside ENT Patient,

Thank you for choosing Northside ENT for your allergy evaluation. This packet and questionnaire **MUST BE READ AND FILLED OUT PRIOR** to your appointment. Bring the entire packet with you when you return for your testing to the Allergy department. Please arrive 10 minutes prior to your appointment time. * **Please allow 60-90 minutes for your testing evaluation.**

About Your Skin Test: Allergy testing is (usually) a two-part procedure.

Allergy Testing Part I: Involves our state-of-the-art *Modified Quantitative Testing (MQT)*. Northside ENT is one of the few healthcare providers in Central Indiana using the MQT testing method. MQT involves the use of plastic, multi-pronged devices which apply the antigens to your back in less than 30 seconds! There is minimal discomfort, and the test is well tolerated by both adults and children. Your test results are read and recorded just 20 minutes after application of the test. Those results will indicate the need for secondary testing, called "Intradermal" testing (Part II). (Not all patients will require this secondary testing.)

Allergy Testing Part II: Involves the placement of Intradermals or small "bubbles" to the surface of the skin on your upper arm. This testing involves minimal discomfort and results are read and recorded in just 15 minutes.

*If the patient is your child, you will be pleased to know that your Allergy Technician has worked with children for many years, including those with physical and mental challenges, both pediatric and adult. Children under the age of 18 must be accompanied by a legal guardian.

* Our Allergy Technicians will be happy to answer any questions or concerns you might have. Feel free to call the office and speak with the Allergy Department at (317) 844-5656**, option 4.**

Medicines that affect allergy skin testing:
Do not take these medications 7 days or longer (as listed below), prior to your appointment:
This is not an all-inclusive list, review the ingredients on the package or ask your doctor or pharmacist.

Antihistamines - First Generation	
Generic Name	**Brand Names**
Azatadine	Optimine
Bromphenarimine	BroveX, Dimetane, Lodrane
Carbinoxamine Maleate	Histex Pd, Palgic and Pediatex
Chlorpheniramine (6 days)	AHIST, Aller-Chlor, C.P.M, Chlo-Amine, Chlor-Allergy, Chlor-Mal, ChlorTrimeton, Chlorphen, Effidac-24, Histex, Ridraman
Antihistamines - First Generation	
Generic Name	**Brand Names**

Clemastine (10 days)	Allerhist-1, Contact 12hr Allergy, Tavist-1
Cyproheptadine (11 days)	Periactin
Dexchlorpheniramine	Polaramine
Diphenhydramine	Actifed Sinus Day, Aler-Tab, Allergy, AllergySinus, Allermax, Aler-Dryl, Altaryl, Banophren, Benadryl, Calm-Aid, Children's Allergy, Compoz Nighttime, Diphedryl, Diphen-Allergy, Diphenhist, Dormin Sleep Aide, Dytan, Dytuss, Genahist, Hydramine, Ibuprofen PM, Nu-Med, Nytol, PediaCare Children's Allergy, Q-Dryl, Quenalin, Scot-Tussin Allergy, Siladryl, Silphen, Simply Allergy, Simply Sleep, Sleep-ettes, Sleep Formula, Sleepinal, Sominex, Tavist, Theraflu, Triaminic, Twilite, Tylenol PM, Unisom Sleep Gels, Valu-Dryl
Dimenhydrinate	Dramamine
Hydroxyzine (8 days)	Atarax, Rezine, Vistaril
Ketotifen	Zatiden
Meclizine HCl	Antivert, Bonine
Methdilazine	Tacaryl
Phenindamine	Nolahist
Promethazine	Chlorpromazine, Phenergan, Promethazine, Prorex 25 & 50, Thorazine
Pryilamine	Nisaval
Trimaparazine	Tremaril
Tripelennamine (7 days)	PBZ & PBZ-SR
Triprolidine	Myidyl, Zymine
Antihistamines - Second Generation	
Astemizole	Hismanal (may take 40 days)
Azelastine	Astelin, Astepro, Dymista, Optivar Ophthalmic eye drops
Cetirizine	Zyrtec
Desloratidine	Clarinex
Fexofenadine	Allegra
Loratadine	Alavert, Claritin
Levocetirizine dihyrochloride	Xyzal
Metquitazine	Primalan, Quintadrill
Olopatadine	Patanase, Pataday and Patanol Opthalmic eye drops
Terfenadine	Seldane
Other	
Theophylline	Theo-Dur, Respbid, Slo-Bid, Theo-24, Theolair, Uniphyl, Slo-Phyllin
Vitamins A,C,D and E	In doses >1000u
Ranitidine (1 day)	Zantac
Cimetidine (1 day)	Tagamet
Nizatidine (1 day)	Axid
Famotidine (1 day)	Pepcid

Benzodiazepines (7 days)			**Atypical Antidepressants/Sedatives (7 days)**	
Clonazepam	Klonopin		Bupropion	Wellbutrin
Diazepam	Valium		Eszopiclone	Lunesta
Lorazepam	Ativan		Mirtazapine	Remeron
Midazolam	Versed		Quetiapine	Seroquel
Alprazolam	Xanax		Trazodone	Oleptro, Desyrel
Temazepan	Restoril		Zolpidem	Ambien
Varenicline	Chantix		Buspirione	Buspar

Tricyclic Antidepressants and Tranquilizers (7 days) You must OK stopping these with the prescribing doctor	
Amitriptyline	Elavil, Endep, Etrafon, Limbitrol, Vanatrip
Amoxampine	Asendin
Clomipramine	Anaframil
Desipramine	Norpramin
Doxepin	Adapin, Sinequan (8 days), Zonalon (+topical) (14 days)
Imipramine (14 days)	Tofranil
Nortriptyline	Aventyl HCL, Pamelor
Protriptyline	Vivactil
Trimipramine	Surmontil

***You must have approval to stop taking any Betablocker medication from the doctor that prescribed it.**
That doctor may want to prescribe a replacement medication for you to take for the 3 days before your testing*This list is not all inclusive. Check with your doctor or pharmacist if your medication contains a betablocker*

Beta Adrenergic Blocking Agents – Betablockers (3 days) Anaphylaxis may be more difficult to treat	
Acebutolol -(B1 selective)	Sectral Capsules
Atenolol -(B1 selective)	Tenoretic 50 & 100, Tenormin
Betaxolol - (B1 selective)	Betoptic & S (Opthalmic / eye drops), Kerlone
Bisoprolol -(B1 selective)	Zebeta, Ziac,
Carteolol (NS)	Cartrol Filmtab Tabs, Ocupress (Opthalmic / eye drops)
Carvedilol (NS)	Coreg
Esmolol HCL (NS)	Brevibloc Injection
Labetalol (NS)	Normodyne, Trandate
Levobunolol	AK-Beta, Betagan Liquifilm(Opthalmic / eye drops)
Levobetaxolol	Betaxon
Metipranolol	OptiPranolol (Opthalmic / eye drops)
Metoprolol -(B1 selective)	Lopressor + Lopressor HCT, Toprol-XL
Nadolol (NS)	Corgard, Corzide, Nadolol Tabs
Penbutolol (NS)	Levatol
Pindolol (NS)	Visken
Propranolol (NS)	Inderal, Inderide
Sotalol - (B1 selective)	Betapace, Sorine
Timolol + Timolol Maleate (NS)	Betimol, Blocarden, Ocumeter, Timolide tabs, Cosopt, Occudose, Timoptic, XE, (Opthalmic / eye drops)

Herbal Supplements: Do not take 7 days before allergy testing:

Decrease test results	Decrease test results		Increase test results
Licorice	St. John's Wort		Milk Thistle
Green Tea (150mg)	Feverfew (500mg)		Astragalus (250mg)
Saw Palmetto(500mg)	Milk Thistle (200 mg)		Licorice (500 mg)

Please refrain from eating large amounts of the following foods 24 hours before testing, they contain natural antihistamines.

Vitamin A - examples: carrots, spinach, mangoes, tomatoes, dark green leafy vegetables.
Vitamin C - examples: apples, berries, citrus fruits, and pineapples
Omega-3/ Fish oil - examples: salmon and walnuts

THE FOLLOWING MEDICATIONS SHOULD BE CONTINUED:

- ALL ASTHMA MEDICATIONS
- Nasal sprays, except those listed above
- You may continue use of: Regular Tylenol, Aspirin, Birth Control, Hormones, Antibiotics

THE DAY OF YOUR TEST:

- Please do NOT apply any lotions to your arms or back.
- Please refrain from using perfumes and colognes until you leave the building. The allergy injection area is nearby. Those patients are very sensitive to fragrance, and may cause them to have respiratory issues.

ALLERGY TESTING AND TREATMENT

The purpose of this form is to insure that your decision to have this evaluation and treatment is NOT made without the knowledge of the possible risks of this medical care. Generalized allergic reactions after skin testing are 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 reaction may appear as a rapid or weak pulse rate. In rare cases, there may be some shortness of breath. These symptoms may require immediate treatment initiated in this office, and possibly continued in a hospital setting.

IN OFFICE TESTING CONSENT

1. I, ______________________________________, authorize Dr. __________________________ and his/her Clinical Staff of Northside ENT, Inc., to perform skin end-point titration to test for food or inhalant allergies.
2. The nature and effects of this procedure, the risks and complications involved (including the provocation of symptoms or possibility of a severe reaction), as well as alternative methods of treatment, have been fully explained to me by the Clinical Staff, and I understand them.
3. I authorize the Clinical Staff to perform any other procedure which he/she may deem desirable in attempting to treat any resulting complications as stated in Paragraph 2, above, or any unforeseen condition that may be encountered during the procedure.

____ ________________________

Witness (Staff) Signature Date

Patient Name: ___________________________________ DOB: _________________

Insurance Company: ______________________________

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EAR, NOSE, AND THROAT SPECIALISTS

Advanced Beneficiary Notice (ABN)

Northside ENT will accept assignment of benefits from me for my insurance and will bill my insurance as a courtesy but it is my responsibility to ensure my insurance company pays for the services provided promptly. We anticipate that your insurance company, based on their medical criteria **MAY or MAY NOT** pay for the item(s) or services(s) that are described below. The fact that your insurer may not pay for a particular item or service does not mean you should not receive it. **It is your responsibility as the insured to know your deductible and coinsurance amounts.**

Description of Item(s) or Service(s):

*95004-Percutaneous Test (Scratch, Puncture, Prick)

*95024-Intradermal Tests

*86003-Allergen Specific IgE Quantitative/Semi Quantitative (RAST)

*95018-Drug Tests (Scratch, Puncture, Prick) with Intradermal-For Penicillin testing

*95076-Ingestion Challenge-For Penicillin testing

- Your maximum cost/fee for allergy skin testing services (which may be required to be paid upon denial by your insurance company) could range from $440.00 to $836.00.
- Your maximum cost/fee for RAST (which may be required to be paid upon denial by your insurance company) could range from $500.00 for food testing or $720.00 for environmental testing. If both tests are ran, the total cost will be $1,220.00.
- Your maximum cost/fee for Penicillin testing (which may be required to be paid upon denial by your insurance company) could range from $132.00 to $477.00.

Insurance Pre-certification / Prior Authorization or Referral Approval: Some insurance companies require pre-certification, prior authorization or a referral from your primary care physician before certain services are provided. It is your responsibility to ensure that precertification, prior authorization, or a referral is obtained. It is **your** responsibility to ensure the services are obtained within the dates that the pre-certification, prior authorization and/or referral are approved. **Failure to do any of the above will make you financially responsible for all denied payments.**

Assignment of Benefits: I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other plans to Northside ENT. This assignment will remain in effect until revoked by me in writing. I hereby agree to pay Northside ENT the charges for all medical services rendered.

Missed Appointments: Appointment must be cancelled 24 hours in advance or there will be a $20 charge.

I hereby accept and acknowledge all of the Policies, Terms, Conditions and Consents above by signing below:

____
Patient or Responsible Party Printed Name

_______________________________________ _______________________
Patient or Responsible Party Signature Date

PATIENT QUESTIONNAIRE

Name: ______________________________ Date of birth: _____________ Date: _____________

Chief Complaint: Briefly explain the major reason you are here to see us and how long this has been a difficulty.____

____

Which of the following symptoms have you experienced? Please circle all that apply.

Hay Fever	Asthma	Hives	Mood Changes
Runny Nose	Cough	Rash	Dark Circles under eyes
Stuffy Nose	Shortness of Breath	Eczema	Fatigue
Sinus Problems	Wheezing	Itching	Ear Infections
Sneezing	TB (Tuberculosis)	Sore Throat	Abdominal Cramps
Itchy Eyes	Tightness in Chest	Bloating	Tonsillitis
Post nasal drip	Phlegm or mucus	Nausea	Decreased Hearing

When are your symptoms worse? (Please check and circle)

_____ Spring, Summer, Fall, Winter, Same year round
_____ Morning, Evening, Bed, No Change
_____ Inside and/or Outside
_____ On weekends _____ with exercise _____ hobbies _____ at work _____

Past Medical History: (Please check)

Have you had any allergic or bad type of reactions to any medications? _____ Yes _____ No
If so, which one(s): ____
Do any foods or beverages bother you (i.e., cause asthma, cramps, rash)? _____ Yes _____ No
Explain: ____
Do you now, or did you ever, smoke? _____ Yes _____ No I Quit ____________________
If yes, what, and how many per day? ____
How many years? ______________ Do members of your household smoke? _____ Yes _____ No

Medical Illnesses: Please List

____
____
____

Surgeries: Please list

____
____
____

Medication List: Name Dose Times per Day

____
____
____
____

Past Allergy and Asthma Medications:

____
____

Environmental History: Check or fill in blank

Residence Type: House _____ Apartment _____ Other _____

Air Conditioning: None _____ Central _____ Room _____

Humidifiers: None _____ Central _____ Portable _____

Basement: _____ Yes _____ No Does your basement smell musty? _____ Yes _____ No

Bedroom where patient sleeps:

Pillows: Foam _____ Dacron _____ Feather _____ Cotton _____

Do you have in your bedroom? Stuffed toys _____ Upholstered Furniture _____ Pets _____

Bed Covers: Cotton Spreads _____ Quilt/Comforter (Down?)_____ Wool Blanket _____

Flooring: Wall to wall carpeting _____ Hardwood _____ Linoleum/Vinyl

Pets: Dog _____ Cat _____ Bird _____ Horse _____ Other ________________

Social History:

Line of work/student? ____

If a child, involvement with day care: ____ Full Time ____ Part Time ____After School

How much alcohol do you drink? Per day/per week? ______________________________________

Recreational drug use (Cocaine, Marijuana, other)? ____

Review of Systems: (Please check the symptoms you have)

Head/Neck:
_____ Migraine headaches
_____ Nosebleeds
_____ Odor of Breath
_____ Hoarseness
_____ Ringing in ears
_____ Broken Nose
_____ Hearing impaired

Cardiovascular:
_____ Heart Murmur
_____ Palpitations
_____ Swelling of legs
_____ Chest Pain
_____ Heart Attack
_____ Angina
_____ Blood Clots
_____ Easy Bruising

Gastrointestinal:
_____ Stomach Ulcers
_____ Difficulty Swallowing
_____ Irritable Bowel
_____ Abdominal Pain
_____ Hepatitis
_____ Pancreatitis
_____ Constipation
_____ Diarrhea
_____ Heartburn

Endocrine:
_____ Diabetes
_____ Thyroid Disease
_____ Heat Intolerance

Musculoskeletal/ Rheumatologic:
_____ Joint Pain
_____ Back Pain
_____ Rheumatoid arthritis
_____ Gout
_____ Lupus
_____ Herniated Disc
_____ Osteoporosis
_____ Fibromyalgia

Neurologic/ Psychiatric:
_____ Dizziness
_____ Stroke
_____ Vertigo (room spins)
_____ Numbness
_____ Tingling
_____ Bell's Palsy
_____ Weakness of an Extremity
_____ Anxiety
_____ Depression
_____ Considered or attempted suicide
_____ Drug Abuse Current/Past