



NORTERRA
FAMILY MEDICINE

Allergy Testing Consent Form

Indication for Procedures: Symptoms of Allergy such as watery, itchy eyes, nasal congestion, sore throat, eczema and rash.

1. I hereby authorize _____ to treat the conditions which appear indicated by clinical exam and/or diagnostic studies already performed or to perform the diagnostic procedures listed below.
2. The procedure(s) necessary to treat my condition or to diagnose it has have been explained to me and I understand the nature of the procedure to be: "Allergy Testing" and "Multi-Test Method"
3. I understand the risks of the procedure include, but are not limited to: red, raised, itchy hives, local swelling, rash, and in severe cases anaphylaxis. These risks are serious and possibly fatal. I also understand that the more common risks of any procedure include: infection and bleeding.
4. It has been explained to me that, during the course of the procedure, unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) than those set forth in Paragraph 2. I, therefore authorize and request that the above named medical provider perform such other procedures as are necessary and desirable in the exercise of professional judgement.
5. I have read and fully understand the above information and have had a chance to have all my questions regarding this procedure answered by _____.

Are you taking Beta Blockers?

Yes

No

Are you pregnant?

Yes

No

Date:

Time:

Signature of Patient/Parent/ or Guardian_____