Allergy, Asthma & Immunology Center
OF SOUTHWEST LOUISIANA

320 Settlers Trace Blvd. Lafayette, LA 70508
2903 1st Ave., Lake Charles, LA 70601
Voice: 337-981-9495 Fax: 337-981-7451

PATIENT CONSENT FOR ALLERGY SKIN TESTING

I authorize Dr. Bernard C. Fruge, Jr., Dr. Bina Joseph, or Dr. Andrew Collins to perform the following diagnostic procedure(s): allergy skin testing

In general terms, the nature and purpose of this diagnostic procedure is to scratch or inject the skin with small quantities of the extracts in order to produce a local wheal (swelling) and flare (redness) to determine sensitivity (allergy) to these materials. The results are read 15-20 minutes after completion of the testing and interpreted by the physician treating you.

I have acknowledged that I have stopped all antihistamines 5 days prior to this testing as they may interfere with test results. These antihistamines include those by prescription and over the counter.

Some risks known to be associated with skin testing are:

a) Syncope (fainting)
b) Hives (welts)
c) Skin Swelling
d) Generalized redness to the skin at site of testing
e) Wheezing
f) Anaphylaxis (sudden, severe generalized allergic reaction)

I have been informed of the probability of occurrence of each of the foregoing risks as the result of or in connection with the allergy testing.

I hereby authorize Dr. Bernard C. Fruge, Jr., Dr. Bina Joseph, or Dr. Andrew Collins to provide such additional services which may deem reasonable and necessary including, but not limited to, the treatment of severe allergic reaction in a hospital or emergency room, using services of the X-ray department, laboratories or hospitalization and that our office is not responsible for any costs associated with these treatments.

The above named procedures may not be performed on all patients. No testing or procedures will be performed without my consent. I understand that the consent must be signed in order for Dr. Bernard C. Fruge, Jr., Dr. Bina Joseph or Dr. Andrew Collins to test and treat me.

I hereby state that I have read and understand this consent, and have had all of my questions about the procedure or procedures and treatment answered to my satisfaction.

THIS CONSENT FORM IS VALID UNTIL REVOKED BY ME IN WRITING!

Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____

Witness: _____ Physician Signature: _____

Date: _____