TALLAHASSEE
ALLERGY, ASTHMA & IMMUNOLOGY
SPECIALIZING IN ADULT AND PEDIATRIC ALLERGIC DISORDERS

BRIAN G. WILSON, M.D.
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BACKGROUND INFORMATION ABOUT
IMMUNOTHERAPY (ALLERGY SHOTS) FOR PATIENTS

The history and physical examination is the most important part of an allergy evaluation; skin tests are informative and help to make a diagnosis of specific allergy. Treatment must take into account your symptoms, allergic exposure, previous treatments, and other medical problems.

Allergy Shots

Immunotherapy or "allergy shots" are administered to allergic patients who have symptoms not controlled by environmental control measures or medications, or which persist and require daily medications.

Effectiveness

Immunotherapy is very effective, because it "turns down" allergic reactions to common pollens, molds, animals and dust. The initial 6 to 12 month course of allergy shots gradually decreases your sensitivity and continuation of injections leads to further improvement. The injections do not completely cure patients but significantly diminish sensitivities, resulting in fewer symptoms and use of fewer medications. It is important to maintain shots at the proper time interval (recommend weekly until maintenance is reached); occasionally missing shots for a short vacation or for some other problem is acceptable. However, for you to get the maximum benefit from allergy shots, they need to be given on schedule.

How long are shots given?

Initially, you will be in the build-up phase of allergy shots. During this time, we will gradually increase your dose each injection until you reach a maintenance dose. It is especially important for you to come in every week for a shot during build-up, usually the first 3-6 months. You may come in every 48 hours during the beginning of your build-up phase. Missing doses during build-up, will delay the time it takes to reach your maintenance dose and will likely delay improvement in your symptoms. Each time you have more than 14 days in between your scheduled doses, your therapy is delayed.

The goal of the maintenance schedule is to increase the interval between shots to 2 to 4 weeks depending upon your allergy sensitivities. After obtaining good results for 3 years, we will assess your improvement and discuss continuing or stopping your shots. You will be re-evaluated periodically while on injections; changes in the allergy extract or injection schedule may be necessary to obtain the best results.

Reactions

It is normal to have allergic reactions that often occur at the injection site (arm), such as redness, swelling, itching or pain; avoid rubbing, patting or kneading your arms. Applying cold packs and taking antihistamines can alleviate these symptoms.

Other allergic reactions may include hay fever type symptoms hives, flushing, lightheadedness, asthma, and, rarely, life threatening reactions. Allergy shots are usually safe and effective if standard guidelines for allergy injections and appropriate safeguards are followed.

Please read the handout entitled ***TAAI Immunotherapy Policy (on back).***

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TAAI IMMUNOTHERAPY POLICY

The following guidelines are very important for safe administration of your allergy injections.

1. Please read this information carefully. This office is open for allergy injections on:
   - Monday and Wednesday 8 am-11 am and 1 pm- 4 pm
   - Tuesday and Thursday 10 am-1 pm and 3 pm-6 pm
   - Friday 7 am-11 am

   No appointment is necessary; simply check in at the front window and notify the staff that you are here for a shot. A 48 hour interval is necessary between injection times.
2. You need to **TAKE YOUR ANTIHISTIMINE** on your **SHOT DAYS**, at least 1 hour prior to receiving your shot.
3. **YOU MUST WAIT IN THE OFFICE AT LEAST 30 MINUTES AFTER RECEIVING YOUR INJECTION** to make certain that you do not experience an allergic reaction. These symptoms consist of any of the following: itchy eyes, nose, or throat, nasal congestion, runny nose, tightness in the throat or chest, coughing, increased wheezing, lightheadedness, faintness, nausea, hives, or generalized itching. Report these or any other symptoms to the nurse immediately so that appropriate treatment may be instituted.
4. **Do not exercise for two (2) hours following your injections(s)**
5. If you have a fever or are wheezing, you should be assessed by the physician before receiving your injection.
6. All injection sites must be checked by a nurse before leaving the office.
7. If, after leaving the office, you experience excessive swelling or tenderness in your arms, please tell the nurse prior to receiving your next injection. If you experience more severe symptoms such as wheezing, generalized rash, or throat swelling, please notify the office immediately.
8. **ALL CURRENT MEDICATIONS OR CHANGES IN MEDICATION (including BETA BLOCKERS)** made by **any** physician must be brought to the attention of the nurse or physician ***before*** receiving your injection. **Notify** the medical staff if there is a possibility that you may be **PREGNANT.**
9. If you are receiving your shots in another physician's office:

   A. It is our policy that injections should only be given by a physician/or nurse. A medical doctor should be in the building at the time of your injection. Adrenalin (epinephrine) and other medications as well as appropriate equipment to treat allergic reactions should be available in the office where you receive your injection therapy.

   B. **Please notify this office at least two weeks in advance if new vials of allergy extract are needed. Always bring your current dosage sheet with you at the new vial visit so that appropriate alterations in the dosage can be made.** This dosage schedule is part of your medical record and the original or a copy should be returned to this office when you return for a new vial evaluation. The date of each injection should be recorded on the sheet.

   C. Please do not discontinue your injections without consulting this office and follow the time intervals outlined by the doctor on the injection sheet for optimal therapeutic results.

   D. If there is an interval longer than one month between injections, you should consult this office by telephone or in person before receiving your next injection.

   E. Do not continue using extract after the expiration date on the label.
10. If you have any questions regarding your injections, these instructions, or allergy symptoms, please contact this office.

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TAAI-OUTSIDE OFFICE POLICY

INSTRUCTIONS FOR GIVING ALLERGY IMMUNOTHERAPY INJECTIONS (PLEASE GIVE THIS PAGE-FRONT & BACK TO THE ADMINISTERING PHYSICIAN)

I. TECHNIQUE: Use a 1 ml disposable syringe and a 26-27 gauge needle. Carefully withdraw the proper amount from the appropriate vial. Cleanse the area with an alcohol swab prior to giving the injection. Give the injection **SUBCUTANEOUSLY** in the posterior aspect of the middle third of the arm. Gently draw back on the plunger and if blood appears, withdraw the needle and select a new site. Slowly inject the extract, withdraw the needle and apply pressure for 15-20 seconds. **Do not massage the area.** Either arm may be used or the arms may be alternated. Allergy extracts should be refrigerated at 4°C at all times. Avoid exposure to direct sunlight, extreme heat or freezing. **Do not administer expired allergy extracts.**

II. 30 MINUTE WAIT: Each patient is required to wait at least 30 minutes in the medical facility after receiving an allergy injection so that he or she can be checked for local and systemic reactions and treated appropriately and promptly. **DO NOT** give an allergy injection unless a physician is present for the entire 30 minute waiting period.

III. MANAGEMENT OF LOCAL REACTIONS:

	Reaction	Next dose
a.	No reaction to swelling 15mm diameter (dime size)	Progress according to schedule
b.	Swelling (not redness) 15-25mm diameter (dime to nickel size)	Repeat same dose
c.	Swelling 20-25mm (nickel to quarter size)	Return to last dose that caused no reaction
d.	Swelling >25mm (quarter size) or persisting > 12 hours	Decrease dosage by 50%*

*If reduced dose is tolerated, increase dose by 0.05 to 0.1cc weekly and resume schedule.
If reaction occurs again, patient should return to see Dr. Wilson with dosage sheet.

NOTE: A lump or swelling with erythema is not as significant as a lump with a wheal (a wheal has a hive-like appearance). The wheal is the most significant part of the local reaction. If the wheal has pseudopods or is surrounded by hives, consult the office.

IV. MANAGEMENT OF SYSTEMIC REACTIONS: Systemic reactions resulting from injections occur occasionally in the course of treating allergic patients. Almost all reactions occur within 30 minutes after the injection. Symptoms may include itching of the palms, hands or other body parts, sneezing, coughing, hives, swelling of the lips or other body parts, wheezing or shortness of breath. With severe reactions, acute asthma or a drop in blood pressure (anaphylaxis) may occur. **At the first sign of a systemic reaction, epinephrine should be administered immediately**. Epinephrine should be given **intramuscularly** into the outer aspect of the thigh at the appropriate dose (about 0.2 mL for children 6 to 12 years, 0.3 mL for patients older than 12). Epinephrine should be repeated if marked improvement does not occur within minutes. Any hypotension or loss of consciousness should be treated first with epinephrine, followed by rapid intravenous infusion of normal saline. Oxygen should be administered if respiratory or circulatory compromise occurs. Antihistamines, glucocorticoids, vasopressors and other medications may be necessary for severe reactions. Occasionally, intubation and cardiopulmonary resuscitation may be necessary. **After any systemic reaction, additional shots should not be given until the patient has returned to this office with all records for reevaluation.**

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V. MISSED INJECTIONS:

During Build-Up Phase		Maintenance Phase	
Days since last injection:	Action:	Days since last injection:	Action:
Up to 14 days	Continue as scheduled	Up to 44 days	Repeat last dose
15 to 20 days	Repeat past dose	45 to 60 days	Reduce dose by 25%**
21 to 28 days	Reduce previous dose by 25%**	61 to 75 days	Reduce dose by 50%**
28 to 35 days	Reduce previous dose by 50%**	>75 days	Contact physician

** Increase dose by 25% per week until back on schedule or back to maintenance dose then resume appropriate schedule

NOTE: If any patient has a history of previous systemic reactions or severe asthma, contact our office to discuss if any additional dose modification is necessary.

VI. ADDITIONAL CONSIDERATIONS:

a. **Refrigeration:** If extract is exposed to extreme heat or cold, or if the extract becomes cloudy, notify the office.

b. **Expiration Date:** Extracts have an expiration date and should not be used beyond that date.

c. **New Serum:** Each time new serum is made the **first injection administered from that new serum must be decrease by half** of the scheduled dose, if that is tolerated like normal the patient can resume to their normal schedule for their next dose.

d. **Beta Blockers:** Beta blockers used concomitantly with allergy immunotherapy are a potential problem because the medications potentiate anaphylaxis. **ADVISE OUR OFFICE IF THE PATIENT IS TAKING ANY BETA BLOCKERS OR ANY OTHER MEDICATION THAT YOU HAVE QUESTIONS ABOUT.**

e. **Pregnancy:** If the patient becomes **PREGNANT**, have her schedule an appointment to discuss her shots.

f. **DO NOT GIVE ALLERGY INJECTIONS IF PATIENT IS WHEEZING OR FEBRILE.**

g. **PATIENT SHOULD NOT EXERCISE FOR 2 HOURS AFTER RECEIVING A SHOT.**

h. **ALWAYS SEND DOSAGE SHEET AND REMAINING VIALS WITH THE PATIENT WHEN HE OR SHE IS RETURNING TO OUR OFFICE FOR NEW VIALS OR DOSAGE ADJUSTMENTS.**

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IMMUNOTHERAPY PATIENT CONSENT FORM

By signing below to start or re-start Immunotherapy (allergy injections) from Tallahassee Allergy, Asthma & Immunology (TAAI) I am acknowledging and consenting to the following:

- I have reviewed the Immunotherapy Background Information and TAAI Policy regarding Immunotherapy; I agree to follow and abide by all TAAI Immunotherapy Policies.
- I have had an opportunity to ask my physician questions regarding the potential side effects of immunotherapy and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.
- I understand Immunotherapy will only be administered with a medical physician present since occasional reactions may require immediate treatment. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the last under extreme conditions. Reactions, even though unusual, can be serious but rarely fatal.
- I agree to **take my antihistamine on my shot days** at least 1 hour prior to receiving my shot.
- I agree to **update** the nurse **prior** to receiving my shot of **any** changes to my medication intake or medical history; including the addition of **BETA BLOCKERS** or the possibility that I may be **PREGNANT.**
- I agree to **WAIT** for **30 MINUTES** after each injection **inside the medical facility**; unless otherwise indicated **ALL MINORS MUST BE ACCOMPANIED by a parent/guardian (see back)** for their entire shot visit **inside the medical facility.** Failure to wait the required amount of time after an injection may make it necessary to modify your treatment.
- I will report any and all adverse reactions to the staff immediately.
- I understand I am making at least a 1 year commitment to weekly injections during the buildup phase and a total commitment of at least 3 years. Missing injections will prolong the length of my therapy.
- I acknowledge once I sign this consent form I am financially liable for all costs associated with my Immunotherapy treatment (TAAI will file any in network insurance that has been provided to them).
- By signing below, I am stating that I am aware of the TAAI Immunotherapy Policy and agree to abide by it.
- Furthermore, I affirm that I will not attempt to have my shots administered by anyone other than then the office of the licensed physician indicated below. If I need to transfer to another physician I will contact TAAI for further instructions and to have a new consent form completed by the new physician.

PATIENT Name _____

Patient Signature/Relationship_____ Date_____
**Parent/Guardian Signature & Relationship if patient is a minor (For Minors See Back for More Information)

Shot Location: ☐ TAAI ☐ FSU **FSU-Initial dose PLUS 1st dose of Red Vial MUST be administered in our Main Office ☐ Amelia Medical ☐ Other (**$15 fee per ship/complete below**) **Signed Consent (below) MUST be received and Shipping fee MUST be paid by patient PRIOR to shipping**

Physician Name_____

Physician Address_____

Physician Phone_____ Physician Fax_____

By signing below, I have read the "TAAI-Outside Office Policy" (2 pages) and I agree to adhere to said policy; I also agree that there will be a licensed physician on site at all times of administration and 30 minute post administration wait time for allergy injections; my office will fax TAAI updated IT administration logs as requested and call with any questions regarding dosing, schedule and reactions.

Physician Signature_____ Date_____

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CONSENT FOR MINORS - - Receiving Immunotherapy without Parent/Guardian present

***PATIENTS UNDER 18:**

I give permission for my son/daughter, _____ (patient) to come in to Tallahassee Allergy, Asthma & Immunology and receive allergy shots every week. He/She may come in with the following sibling(s) (16 yrs old or older) or other adult(s) (ie: grandparent, babysitter, etc) and will follow all requirements of the office as per the TAAI Policy & Consent regarding Immunotherapy. If any alteration in his/her treatment is needed, the office will notify me immediately. I understand that I will need to be present for all office visits with the doctor.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

***PATIENTS 16-18 ONLY:**

I give permission for my son/daughter, _____ (patient) to come in to Tallahassee Allergy, Asthma & Immunology and receive allergy shots every week. He/She may come in alone and will follow all requirements of the office as per the TAAI Policy & Consent regarding Immunotherapy. If any alteration in his/her treatment is needed, the office will notify me immediately. I understand that I will need to be present for all office visits with the doctor.

*Parent/Guardian Signature_____ Date_____