SKIN SENSITIVITY CONSENT FORM

Northland PATHOLOGY

Surname	Given Names	Title	DOB / /
Sex	Address	Phone no.	NHI

PATIENT CONSENT MUST BE COMPLETED BEFORE COMMENCING TESTING

Notes about Allergy Testing and Patient Consent

Allergy testing involves exposing you to various allergens. It is highly unlikely that you will have an adverse reaction to these tests. If you do experience any of the following symptoms during or after the tests please inform a staff member or consult a doctor immediately.

- Excessive itchiness
- Dizziness
- Generalised rash
- Generalised welts
- Difficulty breathing, swallowing or talking

Have you taken any antihistamine medications in the last 72 hours? **Yes** ☐ **No** ☐

Have you applied any skin creams to the area to be tested in the last 24 hours? **Yes** ☐ **No** ☐

Have you ever had a serious allergic reaction, i.e. requiring emergency treatment, ambulance or hospitalisation? **Yes** ☐ **No** ☐

If yes, how long ago? If less than 4 weeks ago DO NOT proceed with the test.

_____

Do you have asthma or a respiratory condition? **Yes** ☐ **No** ☐

If you have answered yes to one or both questions and have any positive reactions you are required to remain in the centre for monitoring for 20 minutes after completion of the test.

Skin Sensitivity testing has been requested by your doctor. Allergens used in testing are the agents most likely to cause your symptoms. In addition, negative and positive 'control' tests are used. The positive control uses a very low dose of histamine, a naturally occurring substance.

Histamine and the allergens used are not registered as drugs in NZ, but are widely used throughout the world. In NZ they can only be used under Section 29 of the *Medicines Act 1981*. This requires the laboratory to notify the supplier with the names of patients who have been tested. The supplier will forward this information to Medsafe, the drug monitoring unit within the Ministry of Health.
The information is maintained in a confidential database as required under the *Medicines Act 1981*.

If you have any concerns please discuss them with your doctor.

I, _____
Print Name (Patient/Parent/Guardian)

have read and understood the Patient Instructions and the above information and consent to the procedure.

Signature: _____ Date: _____