



Michigan ENT
& Allergy Specialists

Skin Test Packet Consent

\$50 CANCELLATION / NO-SHOW FEE

Valued patient-

Due to an increase in cancellations and no-show visits, we have established a cancellation fee of \$50. We ask that you please **commit to your scheduled time or call us 48-hours in advance in order to avoid this fee.**

Certain medications will affect your skin testing results, which include: anti-allergy medicines, antihistamines, anti-cold medicines, stomach medicines, steroids, psych and mental health medicines, heart medicines, eye drops, and others.

We are unable to perform allergy skin testing if you are pregnant. If you are pregnant or think you might be pregnant, please call our office to be rescheduled. We apologize for the inconvenience.

It is very important that you **discontinue appropriate medications up to one week prior to testing in order to avoid this fee.** Please read this entire packet for medication details.

By signing this consent I agree to **read this packet at least one week prior to my testing**, including the list of medications that must be discontinued prior to the testing. I will complete the packet prior to my testing and bring the completed packet with me to my skin test appointment. I acknowledge that I will be responsible for a **\$50 fee** if I either do not cancel within 48-hours of my appointment or do not comply with above instructions. **Please do not bring children under the age of 10.**



ALLERGY SKIN TESTING

Pre-Testing Information

Welcome to MI ENT & Allergy Specialists

At Michigan ENT & Allergy Specialists, we are proud to be your regional specialists in allergic disease. Our expertise ranges from the simple sniffles to the life-threatening potential of peanut allergy. We offer comprehensive testing and treatment in a variety of areas using the purest materials to find the underlying cause of your environmental, food, peanut and tree-nut, asthmatic, penicillin, and other allergy concerns.

SCHEDULED APPOINTMENT TIME

DAY: _____

DATE: _____

TIME: _____



**HOLLAND
HAVEN**
3100 N. Wellness
Holland, MI 49424
49090

Michigan ENT & Allergy Specialists
GRAND HAVEN
1445 Sheldon Road, Ste 303
Grand Haven, MI 49417

GRANDVILLE
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Grandville, MI 49428

SOUTH
205 Broadway St.
South Haven, MI

Phone: 616-994-2770

www.michiganentallergy.com

Fax: 616-920-6533



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- Please read this entire packet -

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Patient Preparation

1) Medication Discontinuation:

Attached is a list of medications that need to be discontinued **up to one week prior** to your skin testing. Please read the list and follow the instructions for any medications you take on the list.

2) Questionnaire:

Please completely fill out the attached allergy questionnaire, **prior** to your appointment. Please bring it with you to your appointment; it helps us gain an understanding of your symptoms and how and when your symptoms affect you.

3) Dress Attire:

We encourage **short sleeves** as skin testing is performed on your arms. Layering with a t-shirt under long sleeves is helpful too. Younger children should wear or bring shorts to the skin testing appointment as sometimes we use the top of the thigh for a testing area. Please do not wear any perfumes, body scents, or colognes on the day of testing.

4) Eat a Snack:

It is important you eat **prior** to your scheduled appointment time. If you are being tested in the morning, eat breakfast; if you are being tested in the afternoon, eat lunch.

5) Need to Reschedule?

If you must reschedule this skin testing appointment, it is very important you contact our office at least **48-HOURS PRIOR** to your scheduled appointment to avoid a **\$50 CANCELLATION/NO-SHOW FEE**.

If you have any questions or concerns please call our office:

616.994.2770

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What to Expect on Day of Procedure

Before Arrival

On the day of your procedure, you should have **already read through this entire skin testing packet** and **discontinued all appropriate medications**. Be sure to double-check the time of your appointment. You will be greeted by our front desk staff who will alert the allergy team of your arrival. Anticipate your testing to take approximately **75-minutes**.

Testing

After the allergy team calls you back and reviews your paperwork, your allergy testing appointment will start with a short and quick breathing test called spirometry. This test measures if you have enough lung function to proceed with testing. After you have passed your breathing test, we move onto actual allergy testing. We utilize two different testing methods to accurately diagnose allergies.

Prick Testing is performed first. This involves putting liquid allergy formulations on the skin and pressing them firmly into the top layers of the skin with a small plastic device. This is generally performed on the forearms, but may be done on the back.

Intradermal testing is performed second. This requires a minimal amount of allergen extract to be injected under the skin to test for further reaction. If you or your child reacts to one of the allergens, your skin will respond with minor swelling, redness and itching.

Your allergy skin test may include testing for many different types of allergens, including:

- Environmental allergens: dust mites, pets, tree pollens, weeds, grasses, and more
- Food allergens: eggs, milk, soy, peanut, and others

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Billing

We understand that finances may play a role in your allergy testing and treatment. Despite most insurance companies providing excellent allergy coverage, we want to provide you with clarity. Below are specific **CPT codes** that will be billed. **You can call your insurance company with these codes to discuss coverage and calculate cost.**

CPT Codes for ALLERGY SKIN TESTING:

Spirometry 94010 – billed once per skin test
 Epicutaneous 95004 – billed for each prick (x32 environmental + x16 foods = x48 total)
 Intradermal 95024 – billed for each intradermal injection (up to 30x per test)

CPT Codes for PENICILLIN ALLERGY TESTING:

Penicillin Test 95018 – billed once per penicillin allergy test

CPT Codes for SUBCUTANEOUS IMMUNOTHERAPY (SCIT, “shots”)

Injections 95115 – billed per injection (weekly) if you receive 1 injection each visit
 95117 – billed per injection (weekly) if you receive 2+ injections each visit
 Mixing 95165 – billed once approximately 9-12 weeks
 Vial Test 95024 – billed once approximately 9-12 weeks

CPT Codes for SUBLINGUAL IMMUNOTHERAPY (SLIT, “drops”)

New Vial \$265 – billed to patient approximately every 12-weeks
 Education 99211 – billed once upon the start of your drop treatment

DIAGNOSIS CODES

Allergic rhinitis due to pollen J30.1
 Allergic rhinitis due to other allergens J30.2
 Food allergy Z91.018
 Penicillin allergy Z88.0

If you have any billing/insurance concerns, please call our billing department:

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Medication Discontinuation

ANTI-HISTAMINES and H2-BLOCKERS

Below you will find the names of several antihistamines and H2-blockers that **need to be discontinued prior to your skin testing appointment**. This list is not a comprehensive list. If you have questions regarding a specific medication – contact MI ENT & Allergy Specialists.

Stop 7-DAYS before testing Stop 4-DAYS before testing

Alavert (Loratadine)	Aller-Chlor
Allegra (Fexofenadine)	Aller-dryl
Allerhist-1	Actifed Sinus
Antivert	Banophren
Astelin	Calm-aid
Atarax	Chlo-Amine
Benadryl (Diphenhydramine)	Chor-Al Rel
Chlorpheniramine	Chlor-mal
Cimetidine	Chlor-Penit
Claritin/Clarinx (Loratadine)	Chlor-Amine
Contac	Chlorphen
Cyproheptadine	Chlor-Trimeton
Deconamine	Compoz Night Time
Doxepin	
Doxylamine	Diphedryl
Dymista	Diphen
Famotidine	Effidac-24
Hydroxyzine	Genahist
Loratadine	Hydramine
Meclizine, Naphcon-A	Nu-Med
Nyquil (also ZzzQuil)	Nytil Caplet
Optivar	PBZ & PBZ-SR
Pataday	Compoz Night Time
Patanol	Phenergen
Pazeo (Olopatadine)	Promethazine
Pepcid	Prorex 25 & 50
Periactin	Ridraman
Quintadrill	Scot-Tussin Allergy
Ranitidine	Sominex
Sinequan	Twilite
Tagamet	
Tavist	
Tylenol PM	
Unisom Sleep Gels	
Vicks, Visine	
Vistaril	
Xyzal (Levocetirizine)	
Zantac	
Zatidor	
Zyrtec (Cetirizine)	

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BETA-BLOCKER MEDICATION

Beta-blockers are common medicines used to treat blood pressure, heart disease, arrhythmias, anxiety, migraine headaches, glaucoma, and many other conditions. Beta-blockers **cannot** be taken prior to skin testing. Beta-blocker medicine must be discontinued **4-days** prior to allergy skin testing. However, **you must contact the physician who prescribed this medication to make sure you are able to safely discontinue this medicine.** If you plan to pursue treatment with allergy shots or drops, beta-blockers must be discontinued indefinitely during this process.

Stop **4-DAYS** before testing

Acebutolol
Atenolol
Betapace (AF)
Bisoprolol
Bisoprolol/hydrochlorothiazide
Brevibloc
Bystolic
Carvedilolol
Coreg (CR)
Corgard
Corzide
Esmolol
Hydrochlorothiazide/metoprolol
Hydrochlorothiazide/propranolol
Inderal (LA)
Innopran XL
Kerlone
Labetalolol
Levator
Lopressor
Lopressor HCT
Metoprolol
Nadolol
Pindolol
Propranolol
Sectral
Sotalol (AF)
Tenoretic
Ternormin
Timolide 10-25
Toprol XL
Trandate
Zebeta
Ziac

EYE DROPS

AK Beta
Betagan
Betaxolol
Betoptic
Carteolol
Kerlone
Levobunolol
Metipranolol
Octipranolol
Ocumeter
Ocupress
Timolol
Timoptic

TOPICAL CORTICOSTEROIDS

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Below you will find the names of topical corticosteroids that **need to be discontinued prior to your skin testing appointment.** This list is not a comprehensive list. If you have questions regarding a specific medication – contact MI ENT & Allergy Specialists.

Stop 21-DAYS before testing

- | | | |
|---------------|-----------------|---------------|
| Aclovate | Desonate | Proctocort |
| Ala-Cort | DesOwen | Proctozone |
| Ala-Scalp | Diprolene | Psorcon |
| Alphatrex | Deiprolene | Rectacort |
| ANucort | Diprolene | Sarnol |
| Anumed | Diprosone | Scalacort |
| Anusol-HC | Elocon | Scalp-Cort |
| Apexico | Embeline | Sernivo |
| Apexicon-E | Florone | Synalar |
| Aristocort | Fluocinonide | Temovate |
| Beta-Val | Flurosyn | Texacort |
| Betacort | Gly-Cort | Topicort |
| Betamethasone | Gynecort | Triacet |
| Betamethacot | Halog | Trianex |
| Betnovate | Halonate | Triamcinolone |
| Caldecort | Hemmorex | Tridesilon |
| Capex | Hemorrhoidal-HC | U-Cort |
| Carmol | Hemril | Ultravate |
| Cetacort | Hytone | Valisone |
| Cinolar | Instacort | Vanos |
| Clobevate | Itch-X | Verdeso |
| Clobex | Kenalog | Westcort |
| Clodan | Keratol | |
| Coraz | Lacticare | |
| Cordran | Lidex | |
| Cormax | Locoid | |
| Cortaid | LoKara | |
| Corticaine | Luxiq | |
| Cortizone | Maxiflor | |
| Cotacort | Mi-Cort | |
| Cutivate | Nolix | |
| Cyclocort | NuCort | |
| Del-Beta | Nutracort | |
| Derma-Smoothe | Olux | |
| Dermarest | Oralone | |
| Dermasorb | Pandel | |
| Dermatop | Pediaderm | |
| Dermovate | Preparation-H | |
| Dermtex | Procto-Kit | |

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PSYCHOTROPIC & MENTAL HEALTH MEDICATIONS

Certain psychotropic medicines act in ways that suppress histamines and affect skin testing. These classes include anti-depressant medications, anti-anxiety medications, sedatives, headache medicines, mood stabilizers, sleep medicines, and many more. These medications must be discontinued as shown below for your skin testing to go appropriately. However, you must contact your prescribing physician for these medicines to make sure you can safely discontinue them.

Stop **5-DAYS** before testing

Ativan (Lorazepam)
Klonopin (Clonazepam)
Valium (Diazepam)
Remeron (Mirtazapine)
Seroquel (Quetiapine)
Xanax (Alprazolam)
Restoril (Temazepam)
Zanaflex (tizanidine)

Stop **3-DAYS** before testing

Ambien (Zolpidem)
Lunesta (Eszopiclone)
Oleptro (Trazodone)
Wellbutrin (Bupropion)
Buspar (Buspirone)
Celexa (Citalopram)
Cymbalta (Duloxetine)
Effexor (Venlafaxine)
Elavil (Amitriptyline)
Lexapro (Escitalopram)
Nortriptyline/Aventyl/Pamelor
Paxil (Paroxetine)
Serzone (Nefazodone)
Zoloft (Sertraline)
Prozac (Fluoxetine)
Pristiq (Desvenlafaxine)
Any Tricyclic Antidepressant

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Allergy Questionnaire

YOUR NAME: _____ DOB: _____ MRN: _____

Office use Only

SYMPTOMS:

Please check any allergy symptoms you may have:

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> cough | <input type="checkbox"/> runny nose | <input type="checkbox"/> nasal polyps | <input type="checkbox"/> eczema |
| <input type="checkbox"/> poor sense of smell | <input type="checkbox"/> nasal congestion | <input type="checkbox"/> wheezing | <input type="checkbox"/> hives |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> itchy nose | <input type="checkbox"/> ear infections | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> chest tightness | <input type="checkbox"/> itchy/watery eyes | <input type="checkbox"/> sinus infection | <input type="checkbox"/> snoring |
| <input type="checkbox"/> headaches | <input type="checkbox"/> postnasal drip | <input type="checkbox"/> blocked ears | <input type="checkbox"/> fatigue |

How long have you had allergy symptoms? _____

What time of year do you suffer most? _____

When are allergies particularly worse for you? indoor outdoor am pm not sure

Do you have pets? no cat dog other

Are your pets allowed in your bedroom? Yes No N/A

Do allergies disturb your sleep? Yes No

Do allergies cause you to miss school or work? Yes No

Have you ever been diagnosed with asthma? Yes No

Have you ever been hospitalized for allergy problems? Yes No

Have you ever had a severe reaction to immunizations? Yes No

What allergy medications have you already tried?

PREVIOUS TESTING:

Have you ever been tested for allergies before? Yes No

Have you had allergy shots before? Yes No If so, did they help? Yes No

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Did you ever have a reaction to an allergy shot? Yes No N/A

YOUR NAME: _____ **DOB:** _____

MRN: _____

MEDICATION ALLERGIES:

Have you ever had an allergic reaction to a medication? Yes No

If yes, please list medication and reaction: _____

FOOD ALLERGIES:

Have you ever had hives or anaphylaxis (difficulty breathing, throat swelling) after eating a certain food?

Yes No If yes, what food? _____

Do foods cause you to have diarrhea, gas, heartburn, nausea, vomiting, and/or chronic abdominal pain? _____

Yes No If yes, what food? _____

SOCIAL HISTORY:

Do you smoke? Yes No

If yes, for how long and how much? _____

Do people smoke in your house? Yes No

Are you pregnant, trying to conceive, or nursing a baby? Yes No

How long have you lived in Michigan? _____

Please list any other areas of residence: _____

What describes your primary place of living: home apartment mobile home other

How do you heat your home? forced air wood stove fireplace other

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Do you have a humidifier on your furnace? Yes No

Is your home air conditioned? Yes No

Do you have a basement? Yes No

Is basement ever damp or moist? Yes No

Please list current occupation: _____

Are you exposed to anything at work or school that aggravates your symptoms? Yes No

If yes, please explain: _____

SIGNATURE: _____

DATE: _____

SNOT-20

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YOUR NAME: _____

DOB: _____ **MRN:** _____

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1. Consider how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel. 2. Please mark the most important items affecting your health (maximum of 5 items)	No Problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be		5 most important items
1. Need to blow nose	0	1	2	3	4	5		<input type="radio"/>
2. Sneezing	0	1	2	3	4	5		<input type="radio"/>
3. Runny nose	0	1	2	3	4	5		<input type="radio"/>
4. Cough	0	1	2	3	4	5		<input type="radio"/>
5. Post-nasal discharge	0	1	2	3	4	5		<input type="radio"/>
6. Thick nasal discharge	0	1	2	3	4	5		<input type="radio"/>
7. Ear fullness	0	1	2	3	4	5		<input type="radio"/>
8. Dizziness	0	1	2	3	4	5		<input type="radio"/>
9. Ear pain	0	1	2	3	4	5		<input type="radio"/>
10. Facial pain / pressure	0	1	2	3	4	5		<input type="radio"/>
11. Difficulty falling asleep	0	1	2	3	4	5		<input type="radio"/>
12. Wake up at night	0	1	2	3	4	5		<input type="radio"/>
13. Lack of sleep	0	1	2	3	4	5		<input type="radio"/>
14. Wake up tired	0	1	2	3	4	5		<input type="radio"/>
15. Fatigue	0	1	2	3	4	5		<input type="radio"/>
16. Reduced productivity	0	1	2	3	4	5		<input type="radio"/>
17. Reduced concentration	0	1	2	3	4	5		<input type="radio"/>
18. Frustrated / restless / irritable	0	1	2	3	4	5		<input type="radio"/>
19. Sad	0	1	2	3	4	5		<input type="radio"/>
20. Embarrassed	0	1	2	3	4	5		<input type="radio"/>

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