Marycliff Allergy Specialists
Richard G. Gower, MD, FACAAI, FACP
Suzanne Levitch, ARNP
Allergy, Asthma & Immunology
Adult and Pediatric

PRE-TESTING INSTRUCTIONS

Please stop ALL antihistamines 5 days prior to your appointment. These include: Allegra, Alavert, Claritin, Clarinex, Doxepin, hydroxyzine, Pepcid, ranitidine, Tagamet, Tavist, Xyzal, Zantac, or Zyrtec. Benadryl or Chlortrimeton may be taken up to 12 hours before your appointment.

Other medication may affect your testing. The following should **NOT** be taken for 3 days prior to testing: antidepressants and beta blockers.

No recreational drugs or alcohol the night before your appointment. Please do NOT use any lotions, perfumes or tanning sprays. Please stay out of the sun if you are being tested.

DO NOT: Go to the dentist the same day as your appointment.
Exercise 2 hours before or after your appointment.
Mow your lawn the day of your appointment.

Specific instructions: N/A or list medications in question:

Please call us before the appointment if you have any questions about medications, your arms are sunburned, you are sick, or are having problems breathing.
We cannot guarantee that your insurance will cover or pay all of the charges incurred for consultation, testing, or antigens and allergy shots. Please call your insurance company if you have questions regarding your coverage.

This is to certify that the risks of Allergy Skin Testing, i.e., patch testing, epidermal (pinprick) and intradermal (injected into the skin) challenges with allergens have been explained to me. I have had the opportunity to ask questions and these have been answered to my satisfaction. I have been informed that the allergen extracts used for this testing are potent and that serious allergic reactions to the testing can occur, although this is rare (less than 0.5% of patients). I understand that these reactions can be life-threatening and accept responsibility for the decision to proceed with the testing. I give consent for treatment of any reactions with epinephrine and/or other appropriate medications and treatment as necessary. I also agree to remain in the medical office for 20 minutes following skin testing.

I reviewed the above information and agree

Patient name:_____ Date:_____
Sign here Please print name here

Marycliff Allergy Specialist:_____ Date:_____

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