

PREPARATION FOR ALLERGY TESTING

There are certain medications that are known to inhibit the allergic response. In order for your test to be accurate **YOU MUST:**

HOLD ALL ANTIHISTAMINES FOR 7 DAYS prior to testing.

An antihistamine is described as ANY drug that is given to reduce OR reverse an allergic reaction. To include but not limited to:

*Benadryl, Allegra, Zyrtec, Claritin, Clarinex, Advil or Tylenol cold/sinus, Actifed, Contac, Nyquil, Chlor-Trimeton, Dimetapp, Drixoral, Allergy eyes, Tavist-D, Contact 12 hr Allergy, Coricidin, Theraflu, **ALSO** Advil or Tylenol **PM**, Atarax, Doxepin, Vistaril, Compazine, Phenergan, Dramamine, Zantac, Unisom, Somnexam and most sleep aids.*

****STOP Astepro, Astelin and Patanase antihistamine nasal spray **3** days prior to testing.**

If unsure if a medication contains an antihistamine please check with your pharmacist.

*****OK to CONTINUE Singulair, Flonase, Fluticasone, Nasonex sprays, and asthma inhalers.**

Caution: BETABLOCKERS are clearly contraindicated for use during allergy testing.

These are examples of such medications however not a complete list, please check with your pharmacist to see if any of your medications are BETABLOCKERS.

Tenormin, Lopressor, Inderal (propranolol), Coreg, Atenolol, Toprol XL, Metoprolol, MAO inhibitors (Nardil, Parnate), Ocupress, Ziac, and Bisoprolol.

Caution: Other medications may be contraindicated for allergy testing such as tricyclic antidepressants because they cannot be stopped.

These are examples of such medications however not a complete list, please check with your pharmacist.

Elavil, Anafranil, Sinequan, Tofranil, Pamelor, Vivactil, and Surmontil

Herbal Supplements that should be stopped for 3 days are:

Licorice, Green Tea, Saw Palmetto, St Johns Wort, Feverfew, Milk Thistle and Astragalus

******If you are on any of the above medications, please let your doctor/nurse know before proceeding with your allergy test.**

Please wear something loose (like a T shirt) on the day of the test so forearms are exposed and the sleeve can be pushed up above the shoulder.

There may be the need to administer Benadryl, Zyrtec or Claritin post-test if you are highly allergic.

DO NOT PLAN TO TRAVEL OR DO ANY STRENUOUS EXERCISE THE DAY OF YOUR TEST.

Allergy test on: _____

Dr. Appt: _____

Please call our office with any questions/concerns or if you need to reschedule appt date/time.

Metro @ 407-351-0675 x 112 (Sharon)

University @ 407-677-0099 x 104 (Stacie)

1ST PHASE OF ALLERGY SKIN TESTING

PRICK TEST



EXAMPLE OF REACTION TO PRICK TEST



THE 1ST PHASE OF TESTING CONSISTS OF 5 STAMPS (8 ALLERGENS EACH) AS SHOWN ABOVE ON THE LEFT. THE STAMP IS ROCKED BACK AND FORTH GENTLY UNTIL ALL ALLERGENS ARE EVENLY DISTRIBUTED (APPROX. 2-3 SECONDS). ALTHOUGH SLIGHTLY UNCOMFORTABLE THIS SHOULD NOT CAUSE PAIN. THE ALLERGENS ARE LEFT ON THE SKIN FOR 15-20 MINUTES AND THE SIZE OF THE REACTION IS RECORDED. THE SIZE OF EACH REACTION DETERMINES IF THE 2ND PHASE OF TESTING IS NECESSARY FOR EACH AND EVERY ALLERGEN.

2ND PHASE OF ALLERGY SKIN TESTING

INTRADERMAL TEST



EXAMPLE OF REACTION TO ID'S



THE 2ND PHASE OF TESTING IS A SERIES OF INTRADERMAL (JUST BELOW THE SKIN SURFACE) INJECTIONS (SHOWN ABOVE ON THE LEFT). EACH ONE A DIFFERENT ALLERGEN AND/OR DILUTION. (CAN BE UP TO 36 TOTAL) ONCE COMPLETE THE TIMER IS SET FOR 10 MINUTES THEN WE MEASURE, RECORD AND SHARE THE RESULTS WITH YOU. YOU WILL THEN EITHER SEE YOUR DOCTOR TO REVIEW RESULTS WITH HIM/HER OR THEY WILL CALL YOU TO DISCUSS THEM.

PLEASE DON'T HESITATE TO CALL WITH ANY QUESTIONS OR CONCERNS.

ALLERGY BILLING

Allergy benefits vary greatly between insurance plans.

**We recommend you contact your insurance company if you have any questions regarding your benefits for allergy testing or treatment.*

** Codes to give insurance company

Allergy Testing

Our allergy tests involve 2 possible tests **(95004 Prick Test, 95024 Intradermal Test). Each test can have up to 35 separate units. Total charges vary depending on how many units are needed.

Allergy Treatment

Allergy treatment includes the allergen vials and injections.

Vials**(95165 Allergy Vial) are prepared before a patient arrives for their shot. The charges are billed to your insurance carrier based on the date the vial was prepared. Each vial lasts 6-10 weeks. If requested, we can provide a charge summary for the vials at your next visit.

Injections **(95115 (for 1), **95117 (for 2 or more). Allergy Injections are charged at each visit.

NO SHOW – CANCELLATION FEES

You have been scheduled for a test or procedure that was recommended by your doctor or physician assistant. Due to the additional length of time needed to perform this test or procedure, a No-Show Fee will apply if our office is not notified of a cancellation within 72 hours of your appointment time. This fee is not covered by insurance and will be your responsibility.

You have been scheduled for allergy testing/vial testing at the time listed below. If you are unable to keep the appointment time listed below, please call . This will allow us the opportunity to offer this time to another patient. You may be charged a \$50 No-Show Fee if our office is not notified within 48 hours of your appointment time.

You have been scheduled for audio testing at the time listed below. If you are unable to keep the appointment time listed below, please call . This will allow us the opportunity to offer this time to other patients. You may be charged a \$50 No-Show Fee if our office is not notified within 72 hours of your appointment time.

You have been scheduled a videostroboscopy. If you are unable to keep the appointment time listed below, please call (407) 677-0099, Ext. 150. This will allow us the opportunity to offer this time to other patients. You may be charged a \$100 No-Show Fee if our office is not notified within 72 hours of your appointment time.

Patient: _____

Date of Birth: _____

Your test/procedure is scheduled for:

Date: _____

Time: _____

At: 7251 University Blvd, Suite 300
Winter Park, FL 32792

1781 Park Center Drive, Suite 210
Orlando, FL 32735

For Office Use Only

Mailed _____	Faxed _____	Given to Patient _____
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