A&CI
ASSOCIATES

# Consent for Patch Testing

Patient Name: _____ Date: _____

I understand that I/my child will be undergoing patch testing. The method of testing has been reviewed and I understand the purpose and need of testing. I understand that patches will be applied for 48 hrs and will require visits to have results read on two different days. I understand that each visit will be billed to my insurance and co-pays will be collected at the time of each visit. During testing I have been instructed to keep testing area dry, avoid excessive sweating and sun exposure. Showering and bathing must be done carefully to ensure dryness of test area.

The results of testing will be reviewed by the doctor or physician assistant and a follow-up visit will be scheduled. Photography may be used to document your patch testing and results. The photos of your back will not contain any identifying information, will be printed in our office, and placed in your chart for future use.

I understand no testing is done without risk. Allergic reactions at site of patch are anticipated. Itching and burning sensations are common with contact allergen testing and may be severe in extremely sensitive patients. Dermatitis flare-ups may occur in some patients during testing. If severe itching or burning sensations occur patch will be removed sooner than 48 hours.

I have been warned of the potential discomfort of allergen patch testing and possible side effects. I have been informed and understand the testing procedure and consent to allow testing to be performed.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

ALLERGY & CLINICAL IMMUNOLOGY ASSOCIATES

180 Fort Couch Road • Pittsburgh, PA • 15241-1041
FAX: 412 • 833 • 7011

1385 Washington Road • Suite 101 • Washington, PA • 15301-9674
FAX: 724 • 228 • 7741

D. LEE MILLER, M.D. RONALD A. LANDAY, M.D. JAMES N. DEANGELO, D.O. MICHAEL J. PALUMBO, M.D. DEBORAH D. ALBRIGHT, M.D. MAUREEN MOESLEIN, PA-C