**ALLERGY CENTRE (Wythenshawe Hospital)**

**Dr Susana Marinho, Consultant Allergist**

**Professor Angela Simpson, Professor of Respiratory Medicine**

**Dr Marina Tsoumani, Consultant Allergist**

**Dr Vincent Crump, Locum Consultant Allergist**

**Dr Georgios Gkimpas, Clinical Fellow in Allergy**

**Dr Samia Azmi, Speciality Trainee (STR) Allergy**

**Dr Jia Li Liau, Specialty Trainee (STR) Allergy**

**Ms Fiona Chew, Allergy Nurse Specialist   
Ms Jenny Addison, Allergy Nurse Specialist                        Contact details**

**Mrs Sam Morgan-Walker, Staff Nurse                                  Secretaries Tel.:** 0161 291 4055 **Ms Jollykutty Joseph, Staff Nurse                                               Secretaries Fax:** 0161 291 4057

**Ms Olayinka Mackay, Allergy Dietitian                                    Specialist Nurses Tel.:** 0161 291 5314

**Mrs Claire Wright, Allergy Dietician                                          Bookings Clerk Tel.**:            0797 376 1446 (day cases)  
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**ALLERGY REFERRAL FOR INVESTIGATION OF**

**SUSPECTED ANAPHYLAXIS DURING GENERAL ANAESTHESIA**

**Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DoB:** \_\_\_\_/\_\_\_/\_\_\_\_\_\_\_\_

**RM2 or NHS number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(please complete or affix patient label)**

Date: \_\_\_/\_\_\_/\_\_\_\_\_\_\_\_\_\_ *(please complete)*

Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(please complete with name and contact details of referring clinician)*

Dear Dr

Thank you for referring this patient for investigation of possible anaphylaxis during general anaesthesia.

It is essential we have as much information about the reaction as possible and I would therefore be obliged if you could:

1. Send a referral with a **narrative of the reaction/events**
2. Complete the enclosed **referral pro-forma;** **we require all sections to be completed fully and clearly, *paying particular attention to all drugs administered prior to the reaction, timing of onset of reaction and time of drug administration.***
3. Send it to us along with any supporting documentation of the reaction, including **copies of the anaesthetic charts**.

If you were not responsible for the care of this patient at the time of the reaction and are unable to provide the information required, we kindly ask you to refer this request on to the responsible anaesthetist.

This approach is recommended by the AAGBI (Association of Anaesthetists of Great Britain and Ireland).

**WE WILL NOT BE ABLE TO PROCEED WITH ANY INVESTIGATIONS OR BOOK ANY APPOINTMENTS UNTIL WE RECEIVE ALL THE INFORMATION REQUIRED.**

Thank you for your co-operation.

Yours sincerely,

**Allergy Centre**

**Wythenshawe Hospital**

**INVESTIGATION OF ALLERGIC REACTIONS DURING GENERAL ANAESTHESIA**

***PATIENT REFERRAL FORM***

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT DETAILS** | | | |
| **Name** |  | | |
| **DoB** |  | **Age** |  |
| **Hospital/NHS No.** |  | **Sex** |  |
| **Date** |  | **Ethnic group** |  |
| **Address** |  | **Telephone** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **REFERRING CLINICIAN (address for correspondence)** | | | |
| **Name** |  | | |
| **Address** |  | **Email**  **(UHSM or NHS.NET only)** |  |
| **Telephone** |  | **Fax** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **ANAESTHETIST (if different from above)** | | | |
| **Name** |  | | |
| **Address** |  | **Email**  **(UHSM or NHS.NET only)** |  |
| **Telephone** |  | **Fax** |  |

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| **SURGEON** | | | |
| **Name** |  | | |
| **Address** |  | **Email** |  |
| **Telephone** |  | **Fax** |  |

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| **PATIENT’S GP** | | | |
| **Name** |  | | |
| **Address** |  | **Email** |  |
| **Telephone** |  | **Fax** |  |

1. **Clinical history – reaction during general anaesthesia**

Source of referral: Anaesthetist ❒ Surgeon ❒ GP ❒ Other ❒ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number or email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. **Reaction details**

**Surgical procedure:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of procedure:** \_\_\_/\_\_\_/\_\_\_\_\_\_\_

Was surgery completed? Yes ❒ No ❒ If not, has another surgery been scheduled? Yes ❒ No ❒

Urgency of future surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of reaction** \_\_\_\_/\_\_\_/\_\_\_\_\_\_ **Time of onset of reaction:** \_\_\_\_\_/\_\_\_\_\_\_**h** (24h clock)

**Timing of reaction:** Occurring *within 1h* of the procedure ❒

Occurring *more than 1h after* the procedure ❒

**Suspected cause** (if any): **1)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; **2)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; **3)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Details of the reaction** | | | |
| **Symptom/Sign** | **Onset DATE and TIME**  **(dd/mm/yy; 00:00h)** | **DATE and TIME resolved**  **(dd/mm/yy; 00:00h)** | **Severity**  **(Mild/Moderate/Severe)** |
| Hypotension |  |  | Lowest BP: \_\_\_\_/\_\_\_\_\_mmHg |
| Tachycardia |  |  |  |
| Bronchospasm |  |  |  |
| Cyanosis/desaturation |  |  | Lowest SpO2: \_\_\_% |
| Angioedema  *(specify distribution)* |  |  | Area(s) affected: |
| Urticaria  *(specify distribution)* |  |  | Generalised / Localised, where? |
| Arrhythmia |  |  |  |
| Flushing  *(specify distribution)* |  |  |  |
| Other (specify) |  |  |  |

* 1. **Drugs / IV fluids / Procedures administered BEFORE the onset of the reaction (please include time of tracheal intubation, LMA insertion, and any other relevant event)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Drugs / other substances (e.g. contrast media, dyes) given before onset of reaction** | | | | |
| **Drug/substance** | **Dose** | **Route** | **Time over which administered**  **(‘STAT’ or min:sec)** | **DATE and TIME given**  **(dd/mm/yy; 00:00h)** |
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| **IV Fluids given before onset of reaction** | | |
| **IV Fluid** | **Volume** | **DATE and approximate TIME started (DD/MM/YY; 00:00h)** |
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* 1. **Drugs / IV fluids administered AFTER the onset of the reaction**

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| **Drugs / IV Fluids given after onset of reaction** | | | | |
| **Drug/Procedure** | **Dose** | **Route** | **Time over which administered**  **(‘STAT’ or min:sec)** | **DATE and TIME given**  **(dd/mm/yy; 00:00h)** |
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| **Comments on response to treatment:** |
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| **Complications and sequelae** | |
| **Event** | **Duration** |
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**Outcome – survived?** Yes ❒ No ❒

**Transferred to:** ICU ❒ HDU ❒ Ward ❒ Other ❒ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. **Anaesthetic techniques and procedures**
     1. **LATEX-free environment:** Yes ❒ No ❒
     2. **Central venous access:** Yes ❒ No ❒

Time: \_\_\_\_:\_\_\_\_\_h Skin Prep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of CVC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was a coated catheter used (chlorhexidine/silver sulfadiazine)? Yes ❒ No ❒

* + 1. **Neuraxial blockade:**  Yes ❒ No ❒

Spinal ❒ Epidural ❒ Epi-spinal ❒

Skin Prep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Neuroaxial blockade** | | | | |
| **Drug** | **Dose** | **Route** | **Time over which administered**  **(‘STAT’ or min:sec)** | **DATE and TIME given**  **(dd/mm/yy; 00:00h)** |
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* + 1. **Peripheral nerve blockade:**  Yes ❒ No ❒

Type of block(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Skin Prep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Peripheral nerve blockade** | | | | |
| **Drug** | **Dose** | **Route** | **Time over which administered**  **(‘STAT’ or min:sec)** | **DATE and TIME given**  **(dd/mm/yy; 00:00h)** |
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* + 1. **Urethral catheterisation:**  Yes ❒ No ❒

Time \_\_\_\_:\_\_\_\_h Antiseptic solution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urethral lubrication/local anaesthetic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of catheter (eg latex, silastic etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + 1. **Skin preparation for surgery and start of surgery:**

Time surgery commenced: \_\_\_\_:\_\_\_\_h Time surgery completed: \_\_\_\_:\_\_\_\_h

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| --- | --- |
| **Skin Preparation** | |
| **Antiseptic** | **DATE and TIME given**  **(dd/mm/yy; 00:00h)** |
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* 1. **Investigations performed prior to referral (please give results if known)**
     1. Were blood samples taken for **Mast Cell Tryptase** measurement? **Yes ❒ No ❒**
* **1st sample** Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result\_\_\_\_\_\_\_

(taken as soon as possible after the reaction)

* **2nd sample** Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result\_\_\_\_\_\_\_

(taken 1-2h after the reaction)

* **3rd sample** Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result\_\_\_\_\_\_\_

(taken ≥24h after the reaction)

* + 1. **Other blood tests:**

Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + 1. If patient had a **cutaneous reaction**, were **pictures** taken? No ❒ Yes ❒ (please enclose)
    2. Case discussed at a multidisciplinary meeting? Yes ❒ No ❒
    3. Reported to the MCA (Medicines Control Agency)? Date\_\_\_/\_\_\_/\_\_\_\_
    4. Reported to the AAGBI National Anaphylaxis database? Date\_\_\_/\_\_\_/\_\_\_\_
  1. **Brief relevant medical history/co-morbidities**

**Please detail any relevant clinical information.**

|  |
| --- |
| **Relevant medical history/co-morbidities** |
|  |

**Please send the completed form together with the following:**

* **Narrative of events**
* **Photocopy of the anaesthetic record and any other previous anaesthetic records**
* **Photocopy of the prescription record**
* **Photocopy of the recovery room documentation**
* **Photocopy of any relevant ward documentation**

**To:**

Allergy Centre (F10)

Wythenshawe Hospital

Southmoor Rd

Manchester

M23 9LT

You can also email us the above scanned documentation at: [mft.allergycentre@nhs.net](mailto:mft.allergycentre@nhs.net)