**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)  
**Dr Azza Aglan, Principal Clinical Psychologist – Allergy        E-mail:** [UHSM.AllergyCentre@MFT.nhs.uk](mailto:UHSM.AllergyCentre@uhsm.nhs.uk)

**ALLERGY REFERRAL FOR INVESTIGATION OF**

**SUSPECTED ALLERGIC REACTION DURING A MEDICAL / SURGICAL PROCEDURE / INVESTIGATION / TREATMENT**

**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 allergic reaction to related to a medical / surgical procedure / investigation / treatment.

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

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 physician.

**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 CARDIAC/RADIOLOGICAL/UROLOGICAL PROCEDURES**

***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** |  |

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

1. **Clinical history – reaction during or related to cardiac/radiological/urological procedure**

Source of referral: Cardiologist ❒ Radiologist ❒ GP ❒ Other ❒ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

* 1. **Reaction details**

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

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

Urgency of future procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Drugs / other substances (e.g. contrast media, dyes) given before onset of reaction** | | | | |
| **Drug/other 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** | **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. **Techniques and procedures**
     1. **CONTRAST MEDIUM** used: Yes ❒ No ❒ **Which?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     2. **LATEX-free environment:** Yes ❒ No ❒
     3. **Central venous access:** Yes ❒ No ❒

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

Type of CVC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coated catheter used? No ❒ Yes ❒ Which? \_\_\_\_\_\_\_\_\_\_\_\_

* + 1. **Neuroaxial 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:**  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:**  Time \_\_\_\_:\_\_\_\_h Antiseptic solution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Type of catheter (e.g. latex, silastic etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + 1. **Skin preparation for procedure:**

Time procedure commenced: \_\_\_\_:\_\_\_\_h Time procedure 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? No ❒ Yes ❒
* **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* + 1. If patient had a **cutaneous reaction**, were **pictures** taken? No ❒ Yes ❒ (please enclose)
  1. **Other medication**

**Please list all drugs the patient is currently taking or was taking at the time of the procedure and when started.**

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| --- | --- |
| **Patient’s regular medication** | |
| **Drug** | **Date started** |
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* 1. **Brief relevant medical history/co-morbidities**

**Please detail any relevant clinical information.**

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

**Please send the completed form, a narrative of events and copies of any relevant supporting 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)