Allergy Centre
Wythenshawe Hospital

NHS
Manchester University
NHS Foundation Trust

ALLERGY CENTRE - Wythenshawe Hospital

Doctors:

Dr S Marinho	Consultant Allergist
Dr M Tsoumani	Consultant Allergist
Dr I Thomas	Consultant Allergist
Dr S Azmi	Consultant Allergist
Dr H Roberts	Specialty Trainee Allergy and Clinical Immunology
Prof A Simpson	Professor of Respiratory Medicine
Dr H Durrington	Honorary Consultant in Respiratory Medicine

Specialist Nurses:
Ms J Addison
Ms H Weller
Ms C Johnson

Specialist Dietitian:
Ms C Wright

Principal Clinical Psychologist:
Dr A Aglan

Contact details:

Secretaries Tel.:	0161 291 4055
Service Fax:	0161 291 4057
Specialist Nurses Tel.:	0161 291 5314
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Service Email:	AllergyCentre@MFT.nhs.uk
Postal Address:	Allergy Centre Wythenshawe Hospital Southmoor Road Manchester M23 9LT

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,

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Wythenshawe Hospital

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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 CONSULTANT ANAESTHETIST (ADDRESS FOR CORRESPONDENCE – PLEASE COMPLETE ALL FIELDS IN CASE WE HAVE QUERIES)			
Name			
Address		Email (UHSM or NHS.NET only)	
Telephone		Fax	

SURGEON (FOR CLINIC CORRESPONDENCE)			
Name			
Address		Email	
Telephone		Fax	

PATIENT'S GP (FOR CLINIC CORRESPONDENCE)			
Name			
Address		Email	
Telephone		Fax	

Clinical history – reaction during general anaesthesia

Reaction details

Surgical procedure: _____ **Date of procedure:** _____

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

Urgency/date 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)** _____

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			
Arrhythmia *(specify)*			
Bronchospasm			
Cyanosis/desaturation			Lowest SpO_2: ___%
Angioedema *(specify distribution)*			Area(s) affected:
Urticaria *(specify distribution)*			Generalised / Localised, where?
Flushing *(specify distribution)*			Generalised / Localised, where?
Other *(specify)*			

Exposures

Drugs / IV fluids / Procedures administered IN THE HOUR BEFORE THE ONSET OF THE REACTION (including premedication)
Please also include any other relevant events (e.g. LMA insertion) or exposures (e.g. Patent Blue dye, radiocontrast media)

Drugs / other substances (e.g. contrast media, dyes) given before onset of reaction				
Drug/other substance	**Dose**	**Route**	**DATE and TIME given (dd/mm/yy; 00:00h or infusion)**	**Comments**

IV colloids/blood products given BEFORE the onset of reaction		
IV colloid/blood product	**Volume**	**DATE and approximate TIME started (DD/MM/YY; 00:00h)**

Management of the reaction

Drugs / IV fluids administered TO TREAT or AFTER the onset of THE REACTION

Drugs / IV Fluids given after onset of reaction				
Drug	**Dose**	**Route**	**DATE and TIME given (dd/mm/yy; 00:00h or infusion)**	**Comments**

CPR required ☐ No ☐ Yes → duration of CPR:

Transferred to: ☐ ICU ☐ HDU ☐ Ward ☐ Other

Comments on response to treatment:

Complications and sequelae– e.g. cardiac, renal, neurological, respiratory, anxiety	
Event	**Duration**

Anaesthetic techniques and procedures

Neuraxial blockade: ☐ No ☐ Yes → ☐ Spinal ☐ Epidural ☐ CSE

Drug	**Dose**	**Route**	**DATE and TIME given (dd/mm/yy; 00:00h or infusion)**	**Comments**

Peripheral nerve blockade: ☐ No ☐ Yes → Type of block(s):

Peripheral nerve blockade				
Drug	**Dose**	**Route**	**DATE and TIME given (dd/mm/yy; 00:00h or infusion)**	**Comments**

LATEX-free environment: ☐ No ☐ Yes

Central venous access: ☐ No ☐ Yes

Type of CVC:

Coated catheter (chlorhexidine/silver sulfadiazine)? ☐ Yes ☐ No

Urethral catheterisation: ☐ No ☐ Yes

Urethral lubrication/local anaesthetic:

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

Surgery/procedure times

Time surgery commenced: (24 h clock) **Time surgery completed:** (24 h clock)

Skin preparation – *please do not leave blank*

Chlorhexidine skin prep by anaesthetist?	☐ No	☐ Yes →	Time(s):	(24 h clock)
Chlorhexidine skin prep by surgeon?	☐ No	☐ Yes →	Time(s):	(24 h clock)
Chlorhexidine-coated iv catheter?	☐ No	☐ Yes →	Time(s):	(24 h clock)
Chlorhexidine medical lubricating gel ?	☐ No	☐ Yes →	Time(s):	(24 h clock)
Povidone-iodine skin prep?	☐ No	☐ Yes →	Time(s):	(24 h clock)
Other skin prep?	☐ No	☐ Yes →	Time(s):	(24 h clock)

Investigations performed prior to referral (please give results)

N.B. It is the anaesthetist's responsibility to obtain the results from the laboratory

Were blood samples taken for Mast Cell Tryptase measurement? ☐ No ☐ Yes

1st sample →	Time		Date		Result
2nd sample →	Time		Date		Result
3rd sample →	Time		Date		Result

Other blood tests:

Test		→ Time		Date		Result
Test		→ Time		Date		Result
Test		→ Time		Date		Result

If patient had a cutaneous reaction, were pictures taken? No ☐ Yes ☐ (please enclose)

Reporting

Case discussed at a multidisciplinary meeting? ☐ No ☐ Yes

Reported to the MHRA? ☐ No ☐ Yes → Date _____ MHRA reference number _____

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