

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
Day Case Enquires: 0797 376 1446
Service Email: AllergyCentre@MFT.nhs.uk
Postal Address: Allergy Centre
Wythenshawe Hospital
Southmoor Road
Manchester
M23 9LT

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	

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: _____

1.1. 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 SpO ₂ : ____%
Angioedema (specify distribution)			Area(s) affected:
Urticaria (specify distribution)			Generalised / Localised, where?
Arrhythmia			
Flushing (specify distribution)			
Other (specify)			

1.2. Drugs / IV fluids / Procedures administered BEFORE the onset of the reaction

Drugs / other substances (e.g. contrast media, dyes) given <u>before</u> 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)

IV Fluids given <u>before</u> onset of reaction		
IV Fluid	Volume	DATE and approximate TIME started (DD/MM/YY; 00:00h)

1.3. Drugs / IV fluids administered AFTER the onset of the reaction

Drugs / IV Fluids given <u>after</u> onset of reaction				
Drug	Dose	Route	Time over which administered ('STAT' or min:sec)	DATE and TIME given (dd/mm/yy; 00:00h)

Comments on response to treatment:

Complications and sequelae

Event	Duration

Outcome – survived? Yes No

Transferred to: ICU HDU Ward Other _____

1.4. Techniques and procedures

1.4.1. CONTRAST MEDIUM used: Yes No Which? _____

1.4.2. LATEX-free environment: Yes No

1.4.3. Central venous access: Yes No

Time: ____:____h Skin Prep: _____

Type of CVC: _____

Coated catheter used? No Yes Which? _____

1.4.4. Neuroaxial blockade: Yes No

Spinal Epidural Epi-spinal

Skin Prep: _____

Neuroaxial blockade				
Drug	Dose	Route	Time over which administered ('STAT' or min:sec)	DATE and TIME given (dd/mm/yy; 00:00h)

1.4.5. Peripheral nerve blockade: Type of block(s): _____ Skin Prep: _____

Peripheral nerve blockade				
Drug	Dose	Route	Time over which administered ('STAT' or min:sec)	DATE and TIME given (dd/mm/yy; 00:00h)

1.4.6. Urethral catheterisation: Time ____:____h Antiseptic solution: _____

Urethral lubrication/local anaesthetic: _____

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

1.4.7. Skin preparation for procedure:

Time procedure commenced: ____:____h Time procedure completed: ____:____h

Skin Preparation	
Antiseptic	DATE and TIME given (dd/mm/yy; 00:00h)

1.5. Investigations performed prior to referral (please give results if known)

1.5.1. Were blood samples taken for **Mast Cell Tryptase** measurement? No Yes

- **1st sample** (taken as soon as possible after the reaction) Time ____:____ Date ____/____/____ Result _____
- **2nd sample** (taken 1-2h after the reaction) Time ____:____ Date ____/____/____ Result _____
- **3rd sample** (taken ≥24h after the reaction) Time ____:____ Date ____/____/____ Result _____

1.5.2. Other blood tests:

Test: _____ Time ____:____ Date ____/____/____ Result _____
 Test: _____ Time ____:____ Date ____/____/____ Result _____
 Test: _____ Time ____:____ Date ____/____/____ Result _____

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

