THE ROTHFELD CENTER
FOR INTEGRATIVE MEDICINE™

I, _____, would like to begin sublingual allergy desensitization (allergy drops) for (environmental inhalants/foods) under the direction of _____ (provider).

I understand that, while improvement in my allergic symptoms is likely, that there is no predicting ahead of time whether they will be beneficial. In addition, I understand that, while I may derive benefits as early as the first bottle of treatment, that achieving full benefits will require 3-5 years of treatment 3 times daily. For fastest results on food allergy treatment it is best to avoid your allergic foods as much as possible.

I have read through the instructions for treatment using allergy drops, understand them and agree to adhere to the protocol outlined.

Specifically, I have reviewed and understand any potential adverse reactions as noted below;

Adverse Reactions: most adverse reactions occur early in the course of treatment and are only local (mouth itching, and upset stomach). They usually occur immediately after taking a dose, but are occasionally delayed for a few hours. Most reactions resolve on their own, but may be reduced by using anti-histamines. More systemic symptoms (generalized itching, hives, or mild asthma) also usually begin within minutes of taking your dose. These reactions also usually resolve on their own, but are more likely to require anti-histamines. Both types of reactions require notification of your provider and sometimes require a modification in your treatment protocol (fewer doses per day) or even a change in your treatment bottle (weaker doses).

While angioedema (swelling of the ears, tongue, lips, eyes, throat, hands/feet or intestines) and anaphylaxis (acute asthma, low blood pressure, loss of consciousness or even death) have never been reported using sublingual drops, these conditions require immediate medical attention. In addition, anyone who has experienced anaphylaxis in the past are required to have an epipen on hand when taking allergy drops.

Patient:_____ Provider:_____

Sig. Patient:_____ Sig. Provider:_____

Date:_____

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