Central Mass Allergy and Asthma Care

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XOLAIR THERAPY PATIENT CONSENT

I, _____ am acknowledging that I will begin my Xolair treatment.
(Print name legibly)

The following points regarding Xolair were reviewed and discussed in great detail:
a. The nature and purpose of Xolair treatment program
b. The risks of the treatment, including the possibility of an allergic reaction as well as the risk that the treatment program may not accomplish the desired objectives
c. The possible outcome of the treatment
d. The available alternative medical treatment
e. The prognosis if the program is not followed
f. The need for regular therapy and follow up (including the need to evaluate my asthma by keeping records of my medication use, symptoms and need for unscheduled care (if applicable))
g. Risk of anaphylaxis and epinephrine use, with proper demonstration of epinephrine auto injector
h. Office policies regarding Xolair (i.e. calling ahead for mixing and scheduled office visit required prior to administration if experiencing increase in asthma symptoms (if applicable))

I have had sufficient opportunity to discuss my condition with my allergist and all of my questions have been answered to my satisfaction. I have read and understand the Xolair treatment information form.

I believe that I have the adequate knowledge upon which to base an informed consent to this program.

I consent to other diagnostic and therapeutic procedures and the monitoring program that the physician decides might be necessary due to unexpected conditions (such as treatment of an allergic reaction).

I have read and fully understand this form.

PATIENT_____ **DATE** _____

PARENT or LEGAL GUARDIAN_____ **DATE** _____

WITNESS_____ **DATE**_____

Patients on Xolair for asthma should have an office visit with their prescribing allergist every 6 months and pulmonary function tests every 1-2 years at minimum, or if there has been an increase in asthma symptoms or to assess response to treatment.