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Venom Checklist

___ Immunotherapy was discussed with the Physician

___ I was given and have reviewed the immunotherapy information packet

___ I have returned the three forms:

Immunotherapy Financial Consent Form
Immunotherapy (Allergy Shots) Consent
Shot Patient Emergency Contact Information

___ I returned these three forms by either:

Completing them in the office
Mailing to: Connecticut Asthma & Allergy Center LLC
Attn: Bottle Room
836 Farmington Avenue Suite 207
West Hartford, CT 06119

I would like to start shots in:

___ Avon ___ Hamden ___ Manchester ___ Middletown ___ West Hartford

Once the Venom Consents are received

1. The physician places the order for your immunotherapy
2. The order is approved and serum is made
3. The office will contact you to set up the first allergy shot appointment and verify the office you will be receiving your injections.



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PATIENT FINANCIAL RESPONSIBILITY – VENOM SHOTS

Patient Name: _____ Insurance Company: _____

Your physician is recommending allergen immunotherapy for you or your child. Please call your insurance company at the Member Services phone number to confirm that this is a covered benefit. Provide the following highlighted procedure codes to the insurance company.

Venom Shot Procedure Codes	
95117	Administration Injection
95145	Single Stinging Insect Venom
95146	Two Single Stinging Insect Venom
95147	Three Single Stinging Insect Venom
95148	Four Single Stinging Insect Venom
95149	Five Single Stinging Insect Venom

Are the injections covered? No YES If yes:
 Do I have a deductible? NO YES \$_____ Deductible Met: \$_____
 Do I have a co-insurance? NO YES _____%
 Do I have a copay? NO YES \$_____
 Is there a maximum/limit on number of 95117 injections? NO YES ___ per: _____
 year/days
 The name of the person you spoke with: _____

Date: ___/___/___ Time: _____ am/ pm Reference Number for Call: _____

This form must be completed, signed and return the our office prior to starting immunotherapy.

Signature: _____ Date: _____

Venom, Facts and Consent

836 Farmington Ave, Ste 207
 West Hartford, CT 06119-1551
 860-232-9911 Phone 860-231-7112 Fax
 www.ctallergy.net



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Facts About Immunotherapy

Venom shots are an attempt to build a tolerance to the insect venom to which you are allergic.

Reactions may occur. There are two types.

A LOCAL reaction usually occurs within 20 minutes after the injection although it may occur later. A local reaction is redness, swelling and itchiness at the site of the injection beyond what you should have from a mosquito bite.

A SYSTEMIC reaction usually occurs within 30 minutes after the injection. The symptoms of a systemic reaction include itchy eyes, itchy ears and throat, coughing, congestion, sneezing, throat tightness and hives. It is potentially life threatening and should be reported AS SOON AS POSSIBLE.

As systemic reactions are possible, all patients are required to wait 30 minutes in the waiting room. UNDER NO CIRCUMSTANCES CAN VENOM SHOTS BE GIVEN AT HOME. Should symptoms of a systemic reaction occur, emergency medical treatment should be sought, either in our office or at the nearest medical facility. After you are stabilized, our office should be notified.

Local reactions on the arm are used as a guide for further treatment and therefore should be reported to the nurse prior to administration of the next shot. Should they become uncomfortable, ice packs and antihistamine can be given. ALL PATIENTS SHOULD CARRY AN ANTIHISTAMINE WITH THEM ON THE DAY OF THE SHOT AND IF YOU HAVE ASTHMA YOU SHOULD CARRY YOUR INHALER WITH YOU. We would like you to be committed to getting your shots on time. If you need to be away for an extended period of time, let us know and arrangements may be made for you to receive your immunotherapy elsewhere.

Once you are receiving your venom shots monthly or every 6 weeks, you are expected to see your allergist on a regular basis at least once per year. Please notify the nurse or physician if you are taking any new medications, specifically beta-blockers, which are used in the treatment of high blood pressure, heart disease and migraine headaches. Patients on beta-blockers should not receive immunotherapy.

Venom patients should have an Epi-Pen or Epinephrine Kit. (Please make sure the expiration dates are good.)



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You or your insurance will be charged at the time of shots for the administration of the shot; extracts are billed separately for some insurance programs. Please call us at (860) 232-9911 if you should have any questions.

Desensitization consists of gradual increases on the strength and dose of venom until a maintenance level of 1cc of mcgm/ml is achieved. Although treatment can vary due to an individual patient's sensitivity, the usual treatment is as follows:

Treatment Schedule

Week #	Patient Receives:
1	3 shots at 30-minute intervals of each venom needed.
2	2 shots at 30-minute intervals of each venom needed.
3	2 shots at 30-minute intervals of each venom needed.
4	2 shots at 30-minute intervals of each venom needed.
5	2 shots at 30-minute intervals of each venom needed. (Patients is receiving top dose in 2 parts)
6	2 shots of each venom and remains in the office for 30 minutes.
7	1 shot of each venom and remains in the office for 30 minutes. (We will now increase time between shots)
8	1 shot of each venom and remains in the office for 30 minutes.
10	1 shot of each venom and remains in the office for 30 minutes.
13	1 shot of each venom and remains in the office for 30 minutes.
17	1 shot of each venom and remains in the office for 30 minutes.
22	1 shot of each venom and remains in the office for 30 minutes.
28	1 shot of each venom and remains in the office for 30 minutes. (From now on shots will be given in 6 weeks intervals)

Questions regarding venom treatment may be directed to our lab nurses in the West Hartford office at (860) 232-9911

I, _____, have been made aware of all the risks involved in receiving venom injection therapy.

 Patient Name

 Patient/Guardian Signature

 Date

 Witness

 Date



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Shot Patient Emergency Contact Information

Today's Date: / /

Patient Name: _____

DOB: _____

Address: _____

Phone Number: _____

1st Emergency Contact: _____

Relationship: _____

Cell Phone: _____

Other Number: _____

2nd Emergency Contact: _____

Relationship: _____

Cell Phone: _____

Other Number: _____

CAAC Physician: _____ **PCP:** _____

Current Medications: _____
