Kirsi Jarvinen-Seppo, MD, PHD, Chief
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Lisa Wilson, MSN, APRN, FNP-C
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Lauren Pedro, RN, BSN
Carrie Waye RN, BSN
Brianne Schmidt, RD, CSP
Amy Fromm, MS, RD, CDN
Laura Mercier, MSW

Your child has been referred by their primary care provider for consultation in the Division of Pediatric Allergy & Immunology at Golisano Children's Hospital at Strong on:

_____at_____ with _____
(Date) (Time) (Provider)

Please arrive 20 minutes early to allow time for parking garage and check-in.

Welcome to Pediatric Allergy & Immunology!! We provide testing and treatment for children and adolescents with various types of skin, food, and environmental allergies. Our health care team consists of physicians, a nurse, nutritionist, fellows, and a social worker. Our team works closely with each other to maintain consistent communication and provide the highest quality of care.

Prior to your visit, please complete the attached questionnaire and collect pertinent medical records and/or previous test results. We may need these even if new testing will be ordered. Please also complete HIPAA discussion form.

Please have your child STOP antihistamine medications (also found in over the counter allergy and cold medication) as follows:

- 2 days prior to the visit: Astelin/Optivar (azelastine), Elestat (epinastine), Alaway/Zaditor (ketotifen), Patanol/Pataday/Patanase (olopatadine), Livostin (levocabastine), Visine-A (pheniramine).
- 4 days prior to the visit: Benadryl (diphenhydramine), Claritin (loratadine), chlorpheniramine, brompheniramine,).
- 7 days prior to the visit: Zyrtec (cetirizine), Xyzal (levocetirine), Clarinex (desloratadine), Allegra (fexofenadine), Vistaril/Atarax (hydroxyzine) Periactin (cyproheptadine.
- 10 days prior to the visit: doxepin.

If unable to discontinue antihistamines or took them inadvertently, please keep your appointment

DO NOT STOP THE FOLLOWING MEDICATIONS:
Montelukast (singulair), Antibiotics, Nasacort, Nasonex, Veramyst, Flonase, Rhinocort, Dymista, Flovent, Pulmicort, Asmacort, Asmanex, Qvar, Advair, Symbicort, Dulera.

The Pediatric Allergy & Immunology Clinic is located on the sixth floor in the Ambulatory Care Building of Strong Memorial Hospital (see next page for map and directions to our office).

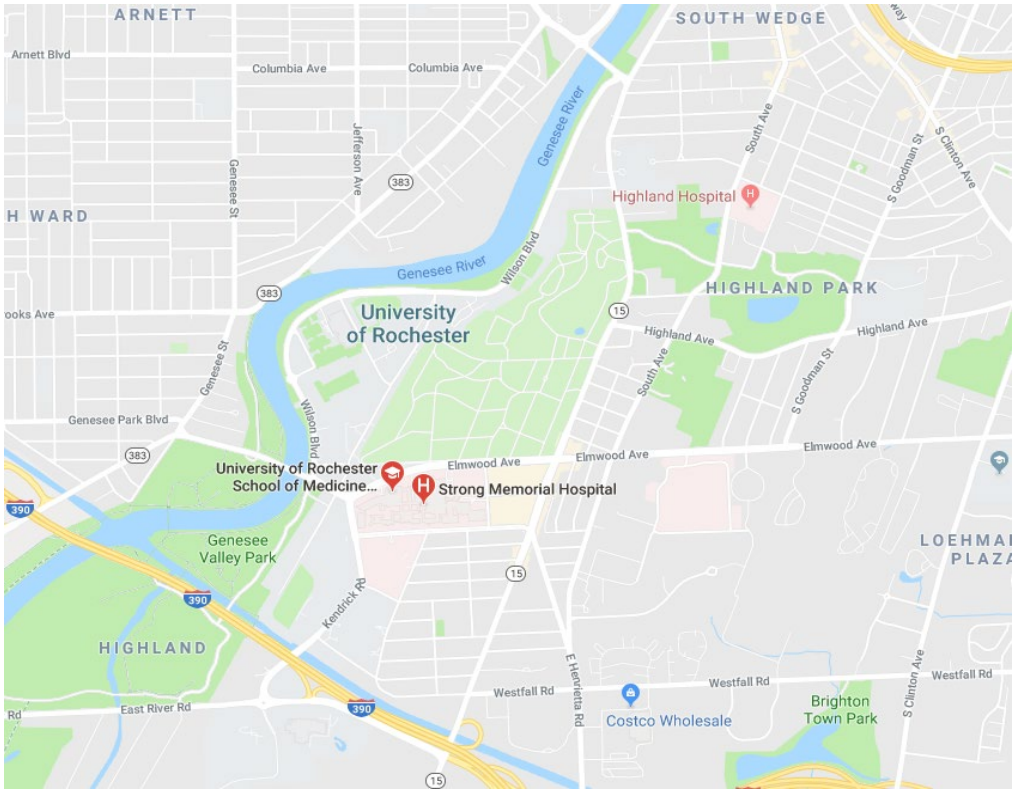
Please allow at least 2 Hours for the appointment.
If you have any general questions or are unable to make it to the appointment, please call our office at the number below at least 24 hours prior to the schedule visit:

601 Elmwood Ave Box 777
Rochester, NY 14642
Phone# 585-276-7190
Fax# 585-756-8054

Visit our website for a "What to expect at your Allergy visit" Online Tour for Children

https://www.urmc.rochester.edu/childrens-hospital/allergy.aspx
Our office hours are Monday-Friday 8:00am-4:30pm. In the event of an emergency outside of normal business hours, you will be connected to our answering service who will contact the doctor on call.

If you haven't already, we would like to encourage you to sign up for **My Chart** which allows you to check labs, request appointments or submit questions and requests to us securely via a patient portal. You can enroll by visiting https://mychart.urmc.rochester.edu/mychart/ or by calling 585-275-8762 or 888-661-6162.



From the South and Thruway (Exit 46):
Take I-390 North to Exit 16(W. Henrietta Rd.) then turn right on W. Henrietta Rd. (Rt 15). Proceed two miles and make a left turn on Elmwood Ave. The parking garage will be on the left.

From the North:
Take I-390 South to Exit 16(W. Henrietta Rd.) then turn left on W. Henrietta Rd. (Rt 15). Proceed two miles and make a left turn on Elmwood Ave. The parking garage will be on the left.

From the Parking Garage to the Pediatric Specialties Office:
Take the garage elevators to the 1st floor. As you enter the hospital, walk straight ahead to the silver elevators, which are on the left, and take the elevators to the sixth floor and proceed to **Suite B**. **By bus**, you will enter the bus entrance of Strong Memorial Hospital (Elmwood Ave.), go left, take the first right to the silver elevators, take the elevators to the sixth floor, and proceed to **Suite B**.

If you are arriving by car, it is best to park in the ramp garage.

Time	Rate
0-30 Minutes	FREE
31 - 60 Minutes	$3.00
61 Minutes - 2 Hours	$5.00
2 Hours – 24 Hours	$6.00

PATIENT E-MAIL CONSENT FORM

Patient Name: _____DOB _____

Patient MR#:_____

Patient E-mail:_____

Provider: _____

Provider E-mail:_____

Personal Representative*:

Name: _____

Relationship: _____

E-Mail: _____

** see HIPAA Policy 0P16 Personal Representative*

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider. These include, but are not limited to, the following:

a) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) E-mail senders can easily misaddress an E-mail.
c) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
e) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
f) E-mail can be used to introduce viruses into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

The Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The Patient and Provider must consent to the following conditions:

a) E-mail is not appropriate for urgent or emergency situations. The Provider cannot guarantee that any particular E-mail will be read or responded to.
b) E-mail must be concise. The Patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
c) E-mail communications between patient and provider will be filed in the Patient's permanent medical record.
d) The Patient's messages may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.
e) The Provider will not forward patient-identifiable E-mails outside of the URMC healthcare system without the Patient's prior written consent, except as authorized or required by law.
f) The Patient should not use E-mail for communication regarding sensitive medical information.
g) It is the Patient's responsibility to follow up and/or schedule an appointment if warranted.
h) Recommended uses of patient-to-provider E-mail should be limited to:
a. Appointment requests
b. Prescription refills
c. Requests for information
d. Non-urgent health care questions
e. Updates to information or exchange of non-critical information such as laboratory values, immunizations, etc.

3. INSTRUCTIONS

To communicate by E-mail, the Patient shall:

a) Avoid use of his/her employer's computer.
b) Put the Patient's name in the body of the E-mail.
c) Put the topic (e.g., medical question, billing question) in the subject line.
d) Inform the Provider of changes in the Patient's E-mail address.
e) Take precautions to preserve the confidentiality of E-mail.
f) Contact the Provider's office via conventional communication methods (phone, fax, etc.) if the patient does not receive a reply within a reasonable period of time.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Provider and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by Email. I agree to use only the pre-designated e-mail address specified above. Any questions I may have had were answered.

Patient or Personal Representative Signature _____Date_____
Provider signature _____Date_____

SH 42 (09/2005) Original – to be retained in Medical Record Copy – to be given to the Patient/Personal Representative

Patient Questionnaire

First Name: _____
Last Name: _____ Date of birth: _____

Referring and/or Primary Care Provider (PCP):
_____
Address of referring provider:
Street: _____ City: _____
State: _____ Zip code: _____ Phone Number: _____
Fax Number: _____

Reason for today's visit**:** _____

What specific questions/concerns are most important to address at today's visit:
_____
_____

Past Medical/Surgical History (If none please skip to the next section):

Please indicate which diagnoses have been made for your child:

___Allergic rhinitis (hay fever)	___Drug allergy	___Hives
___Allergic cough	___Ear infections (recurrent)	___Immune deficiency
___Angioedema	___Eosinophilic esophagitis	___Stinging insect allergy
___Asthma/Reactive airways	___Esophageal reflux disease	___Nasal polyps
___Atopic dermatitis/Eczema	___Food allergy	___Lupus/Rheumatologic diseases
___Bronchiolitis/Bronchitis	___Frequent upper respiratory	___Pneumonia
___Contact dermatitis	infections	___Sinusitis (chronic)

Other Medical History _____

Adenoidectomy	Yes	No	Tonsillectomy	Yes	No
Sinus surgery	Yes	No	Ear tubes	Yes	No

Other surgical history _____

Has your child seen an **allergist** before? Yes No
If Yes Name of doctor _____
Has your child been **skin** tested for allergies before? Yes No
*** If yes, please bring test results**
Has your child had **blood** tested for allergies before? Yes No
*** If yes, please bring test results**

Current Medications (If none please skip to the next section):

Please list all medications your child is taking (include dose and times given):

Name of Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Birth History:
Gestational age: _____ Delivery method: Vaginal C-Section

Complications during pregnancy/delivery/neonatal period? Yes No
If so what were they: _____

Social history:
Does the child attend daycare/school? Yes No

School Name_____ Grade _____

Who lives at home with the child? _____

Immunizations:
Are you child's immunizations up to date? Yes No
Have there been any adverse reactions to immunizations? Yes No
If yes, please explain _____

Environmental history:
Do you have any pets? Yes No
What type of pets? _____
Any other animals at home? Yes No
If yes, list _____

Pest infestation at home? Yes No

Mice Rats Cockroach Termite

Is there tobacco smoke exposure in home or at daycare/caregiver's home? Yes No
Does the patient use electronic cigarettes (vaping)? Yes No
Does anyone who lives in the household use electronic cigarettes (vaping)? Yes No

Review of Systems:
Please circle any of the following symptoms your child is **currently experiencing**:

Runny nose	Wheezing	Abdominal pain	Swelling	Irritability
Nasal congestion	Cough	Vomiting	Rash	Headache
Itchy eyes/nose	Shortness of breath	Diarrhea	Hives	
Poor growth/weight gain		Sneezing	Chest tightness	
Blood in stools	Recurrent infections		Sore throat	
Hoarse voice	Difficulty swallowing		Swollen lymph nodes	
Post nasal drip	Snoring	Heartburn/reflux	Fever	

Family History: **Unknown (Child Adopted):** Yes No

	Food allergy*	Allergic rhinitis / Environmen	Asthma	Atopic eczema / Dermatitis	Eosinophilic esophagitis	Bee sting / Venom Allergy	Immune deficiency	Lupus/ rheumatologic disease	Repeated infections	Sinusitis	Thyroid disease	other
Mother												
Father												
Sister												
Brother												
Other:												

For food allergies, please specify what foods and symptoms:
_____
_____

Food Allergy History (If none please skip to the next section):

If your child has had allergic reactions after eating certain foods, please list:

Food	Date or age of child at reaction	Amount of food	Type of exposure (ie. ingestion, contact)	Symptoms

What foods are excluded from your child's diet?

_____

Which of these foods, if any, are not strictly excluded (e.g. has small amounts as an ingredient)?

_____

Please list any foods that are avoided purely on the basis of previous testing or advice (there has never been a reaction or ingestion):

_____

Does your child complain of itching in the mouth after eating raw fruits or vegetables?
Yes No

Eczema/Atopic Dermatitis History (If none please skip to the next section):

What are the triggers for eczema flares?

_____

How often does your child take a bath? _____
How long is the bath? _____
What soap/cleaner do you use? _____
What moisturizer do you use? _____
What medications (topical or oral) have been helpful?

_____

What medications have not been helpful?

_____

Is there daytime itching? Yes No
Night time itching? Yes No
If yes, does this impact sleep? Yes No

What have you used to control itching?

_____

Has the skin ever been infected, requiring antibiotics?

_____

Environmental Allergy History (If none please skip to the next section):
Yes No
Does your child have allergic symptoms during certain seasons?
Yes No
If yes, which season and what type of symptoms?
Spring _____ Summer _____
Fall _____ Winter _____

Does your child have allergic symptoms after exposure to animals?
Yes No
If yes, which animal and symptoms? _____

Has your child received allergy shots before?
Yes No
If yes, when and for how long? _____

Asthma/Wheeze/Cough History (If none please skip to the next section):

Age of asthma/wheezing diagnosis _____
Triggers for asthma (circle all that apply):

Cold weather Exercise Colds/Illnesses Animals Humidity Eating/reflux

Other triggers_____

The following questions address symptoms of cough, wheeze, shortness of breath, etc.
Please circle how often these occur:

1. How often does your child experience symptoms?	2 times a week or less	More than 2 times a week	Everyday	Several times a day
2. How often does your child wake up from sleep due to symptoms?	2 times a month or less	3-4 times a month	More than once a week	Every night
3. How frequently does he/she use Albuterol and/or Xopenex?	2 days a week or less	More than 2 days a week	Everyday	Several times a day
4. Does the asthma cause any limitation with activity?	None	Minor	Some	Very limited
5. How many times per year does your child have exacerbations?	0-1 time a year	2 times a year	3 times a year	More than 3 times a year

How many times has your child needed oral steroids (i.e. orapred, prednisone) in the past 12 months? _____

Has your child ever been prescribed an inhaler ("asthma pump")? Yes No
Has your child ever been hospitalized for respiratory symptoms? Yes No
If yes, has your child ever been in the intensive care unit (ICU)? Yes No

Drug Allergy History (If none please skip to the next section):

If your child has had allergic reactions after taking certain medications, please list:

Drug name	Date or age of child at reaction	Type of exposure (ie. ingestion, injection)	Symptoms

Other Allergy History (If none please skip to the next section):

Has your child had a suspected allergic reaction to insect stings? Yes No
If yes, please specify: _____

Does your child have recurrent infections? (ear infections, pneumonia, skin infections, meningitis etc.) Yes No

If yes, please list type and how often: _____

Any other information you would like us to know:

_____

_____

_____

601 Elmwood Avenue ·Box 777. Rochester, NY 14642
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