



Kirsi Jarvinen-Seppo, MD, PHD, Chief  
Jeanne Lomas, DO  
Jessica Stern, MD  
Maria Slack, MD, MS  
Puja Sood Rajani, MD  
Lisa Wilson, RN  
Brienne Schmidt, RD  
Jennifer Auchu-Ricotta, LMSW, M.Ed. (Social Worker)

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 15 minutes early to allow time for parking 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.

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.

**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, Periactin (cyproheptadine).
- 7 days prior to the visit: Zyrtec (cetirizine), Xyzal (levocetirine), Clarinex (desloratadine), Allegra (fexofenadine), Vistaril/Atarax (hydroxyzine).
- 10 days prior to the visit: doxepin.

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



**DO NOT STOP** topical steroids for:

- The nose - Nasacort, Nasonex, Veramyst, Flonase, Rhinocort, Dymista.
- The lungs: Flovent, Pulmicort, Asmacort, Asmanex, Qvar, Advair, Symbicort, Dulera.
- Or for the skin.

**Please do not stop:** montelukast (singulair), antibiotics.

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).

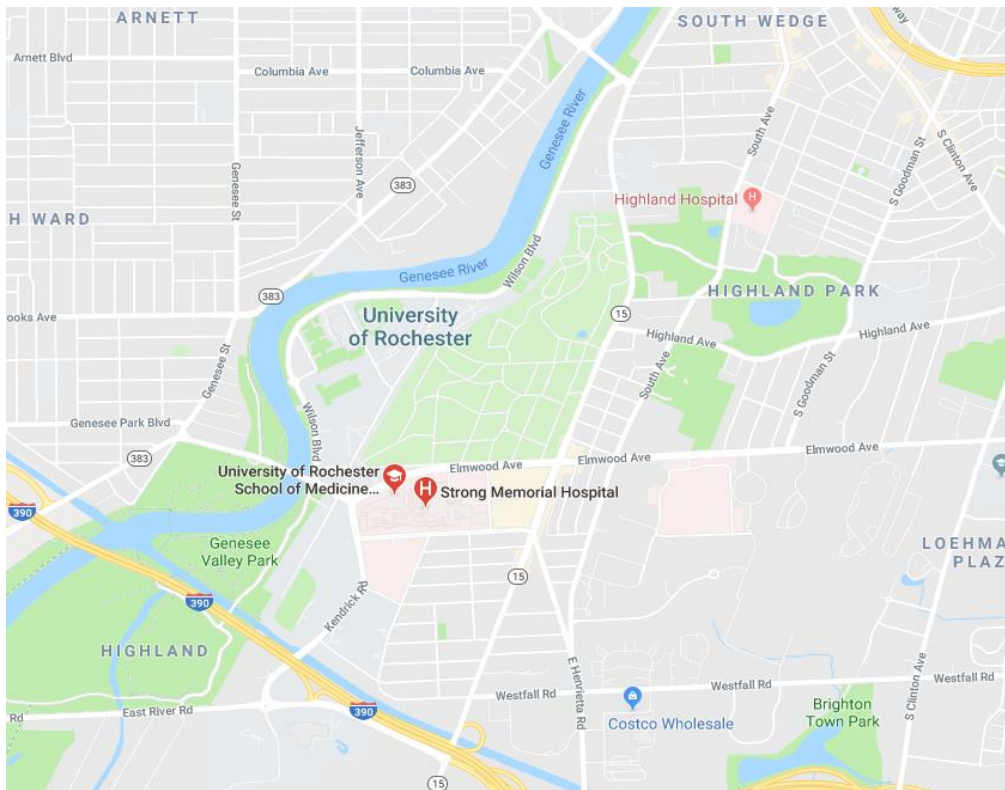
**Please allow at least 2 Hours for the appointment.**

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

<https://www.urmc.rochester.edu/childrens-hospital/allergy.aspx>

Our office hours are Monday-Friday 8:30am-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.



**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 1<sup>st</sup> 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.**

<u>Time</u>	<u>Rate</u>
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 URMHC 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:
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allergic rhinitis (hay fever) | <input type="checkbox"/> Drug allergy                          | <input type="checkbox"/> Hives                        |
| <input type="checkbox"/> Allergic cough                | <input type="checkbox"/> Ear infections (recurrent)            | <input type="checkbox"/> Immune deficiency            |
| <input type="checkbox"/> Angioedema                    | <input type="checkbox"/> Eosinophilic esophagitis              | <input type="checkbox"/> Stinging insect allergy      |
| <input type="checkbox"/> Asthma/Reactive airways       | <input type="checkbox"/> Esophageal reflux disease             | <input type="checkbox"/> Nasal polyps                 |
| <input type="checkbox"/> Atopic dermatitis/Eczema      | <input type="checkbox"/> Food allergy                          | <input type="checkbox"/> Lupus/Rheumatologic diseases |
| <input type="checkbox"/> Bronchiolitis/Bronchitis      | <input type="checkbox"/> Frequent upper respiratory infections | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Contact dermatitis            |  | <input type="checkbox"/> 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



**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 / Environment	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:

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**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?

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

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

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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?

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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?

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What medications have not been helpful?

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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?

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Has the skin ever been infected, requiring antibiotics?

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**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 \_\_\_\_\_





