**NAP6 PERIOPERATIVE ANAPHYLAXIS:**

 **ALLERGY CLINIC REFERRAL FORM (4 pages)**

**Patient details**

Name……………………………………………………………............................................

Date of birth .…. /…./…….. Hospital / NHS Number ………………………….

Address ………….………………………………………………………................................

……………………………………………………… Telephone ……………................……

**Referring consultant anaesthetist (for clinic correspondence)**

Name…………………………………………………………………...

Address…………..………….…………………………………………

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Telephone…………………… Secure Email ……………………

**Patient’s GP (for clinic correspondence)**

Name…………………………………………………………………...

Address…………..………….…………………………………………

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Telephone…………………… Secure Email ……………………

**Surgeon (for clinic correspondence)**

Name…………………………………………………………………...

Address…………..………….…………………………………………

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Telephone…………………… Secure Email …………....…………

**Date of the reaction .…./…../20.... Time of onset of reaction ….../…...h (24h clock)**

**Suspected cause of the reaction**

1) ………………………........... 2) ……………........……..…… 3) …………………............…..…

**Proposed surgery or other procedure : ……………………………………………….……..**

Was surgery/procedure completed? Yes [ ]  No [ ]

If ‘no’, has another date for surgery being scheduled? Yes [ ]  No [ ]

Urgency/Date of future surgery.……………………………………………………………...

**Drugs administered IN THE HOUR BEFORE THE REACTION (including pre-med).**

**Please include any other relevant events or exposures, eg, Patent Blue dye**

|  |  |  |  |
| --- | --- | --- | --- |
| Drug or Event  | Time (24 hr clock)  | Route of drug administration | Comments |
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**IV Colloids/blood products given *BEFORE the onset of the reaction* with start times**

1 ………………….. \_\_\_\_\_:\_\_\_\_\_ 3………………….. \_\_\_\_\_:\_\_\_\_\_

3 ..………………… \_\_\_\_\_:\_\_\_\_\_ 4 ..………………… \_\_\_\_\_:\_\_\_\_\_

Neuraxial blockade Spinal [ ]  Epidural [ ]  CSE [ ]

|  |  |  |
| --- | --- | --- |
| Drug/Procedure | Time (24 hr clock) | Route |
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Peripheral nerve/regional block Type of block(s) .........…………………………

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| --- | --- | --- |
| Drug | Time (24 hr clock) | Route |
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Latex-free environment? Yes [ ]  No [ ]

Chlorhexidine skin prep (by anaesthetist) Yes [ ]  No [ ]  Time(s) ......................

Chlorhexidine skin prep (by surgeon) Yes [ ]  No [ ]  Time ..........................

Chlorhexidine medical lubricant gel Yes [ ]  No [ ]  Time ..........................

Chlorhexidine-coated intravascular catheter Yes [ ]  No [ ]  Time .......................

**Drugs and IV fluids given to treat the reaction**

|  |  |  |  |
| --- | --- | --- | --- |
| Drug /IV fluid  | Time (24 hour clock)  | Route  | Comments on response to treatment |
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**CPR required Yes** [ ]  **No** [ ]  **Duration of CPR ........................**

**Adverse sequelae from this reaction e.g. cardiac, renal, neurological, respiratory, anxiety...................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................**

**Investigations performed before referral (please give results)**

**NB It is the anaesthetist’s responsibility to obtain the results from the laboratory**

Were blood samples taken for mast cell tryptase (MCT)? Yes [ ]  No [ ]

First MCT sample Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result……..........…….

Second MCT sample Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result………..............

Third MCT sample Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result…..........……….

Other blood tests:

Test:…………….......…… Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result………………………

Test:………….......……… Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result………………………

Case discussed at a multidisciplinary meeting? Yes [ ]  No [ ]

Reported to the MHRA Yes [ ]  No [ ]

By whom? ……………………………………

MHRA Reference Number ...................................

**Please send the completed form to the allergy clinic together with:**

* Photocopy of the anaesthetic record and any previous anaesthetic records
* Photocopy of the prescription record (if relevant)
* Photocopy of relevant recovery-room documentation
* Photocopy of relevant ward documentation

*Please file a copy of this form in the patient’s medical record*