**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…………..………….…………………………………………

………………………………………………………………………....….

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

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

Name…………………………………………………………………...

Address…………..………….…………………………………………

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

**Surgeon (for clinic correspondence)**

Name…………………………………………………………………...

Address…………..………….…………………………………………

………………………………………………………....………………….

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**

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| --- | --- | --- | --- |
| 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**

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| --- | --- | --- | --- |
| 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*