VIRGINIA
EAR NOSE & THROAT
The Choice is Clear

Date: _____

RE: Patient: _____

Date of Birth: _____

Dear _____:

We recently evaluated the above-referenced individual for allergic rhinitis. Because of continued symptoms despite allergen avoidance and medications, the patient would like to begin immunotherapy as part of the treatment regimen. In reviewing the medications, we note the patient is taking a beta blocker. Patients on beta blocker medications may have increased susceptibility to severe allergic reactions, including reactions to allergy injections. Moreover, treatment of allergic, asthmatic and anaphylactic reactions with epinephrine may be markedly less effective in the event of a reaction to immunotherapy.

I have asked that the patient schedule an appointment with you to discuss whether another medication can be substituted for the beta blocker that is currently being prescribed. In addition, we would like clarification of the underlying condition requiring beta blocker therapy since cardiovascular disease and congestive heart failure are relative contraindications to immunotherapy. If the beta blocker cannot safely be substituted, can it safely be held for 24 hours prior to each allergy shot? Allergy shots are typically administered once weekly the first year, twice monthly the second year, and once monthly for years three through five. We would also appreciate your input as to whether epinephrine can be safely administered in this individual in the event anaphylactic reactions were to occur.

If you would like to discuss this please do not hesitate to contact me at 804-484-3700 extension 2034. Otherwise we appreciate your timely consideration of this matter.

Sincerely,

Emily Kane, FNP-BC

Attached is an authorization for Virginia Ear Nose & Throat to treat the patient as you have consented. **Please sign and fax back to (804)282-6900**.

BETA BLOCKER AUTHORIZATION PHYSICIAN SIGNATURE FORM

VIRGINIA EAR NOSE & THROAT ASSOCIATES

Patient: _____

Date of Birth: _____

Patient Number: _____

Please sign under the appropriate statement;

I have **approved** patient to hold beta blocker 24h prior to shot.

_____ _____
Physician Signature Date

I have **changed** patient's medication to a non beta blocking agent.

_____ _____
Physician Signature Date

I have **denied** this request as my patient needs therapy as I have ordered.

_____ _____
Physician Signature Date