# ALLERGY ASSESSMENT FORM

Please use a separate form for each medication the patient has identified as an allergy.

Patient: Pharmacist: Date:

| **Drug Allergies** | |
|---|---|
| 1. Name of the medication to which patient reacted | |
| 2. In what year did the allergic reaction occur? | |
| 3. How was the medication given? | ☐ Orally ☐ Intravenously ☐ Injection ☐ Other: |
| 4. Does the patient remember how soon after taking this medication the reaction occurred? | ☐ Within 24 Hours ☐ 1-3 Days ☐ >3 days |

5. What type of reaction did the patient have? (Check all that apply)

☐ Hives/Welts
☐ Shortness of breath/trouble breathing
☐ Wheezing
☐ Chest tightness
☐ Tightness in throat
☐ Passed out
☐ Nausea, vomiting, diarrhea, cramping
☐ Other type of rash – please describe

Swelling ☐ Eyes ☐ Face ☐ Lips ☐ Tongue ☐ Other (please specify):

Other type of reaction – please describe:

a) Has the patient taken **this drug or similar drugs** since the reaction?

☐ No ☐ Don't know ☐ Yes – if yes, list similar meds:

b) Has the patient seen an **allergist** and had testing done? ☐ Yes ☐ No

**Drug Allergy Assessment**

☐ **No known drug allergies**

☐ **Contraindication –** drug causes life-threatening reaction, patient should never receive the drug.

☐ **Caution –** drug causes a moderate to severe side effect; patient should avoid if possible but may receive with monitoring if benefit outweighs the harm

**Drug Allergy – Pharmacist Action where applicable**

☐ **Educate** the patient on their allergy (i.e. intolerance vs. true allergy), drugs to be avoided, and refer to allergist

☐ Recommend **EpiPen™ and Allergy Alert Bracelet**

☐ **Update allergy status** on pharmacy site documentation, including Pharmanet

**Does the patient have any Non Drug Allergies?**

☐ None

☐ Fish ☐ Eggs ☐ Peanut ☐ Lactose ☐ Contrast Media ☐ Latex ☐ Other

Adapted with Permission: Providence Health Care Practice Standard IDG1064 – Allergy/Intolerance. November 2013.

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