**East Yorkshire Regional Adult Immunology and Allergy Unit**

**Pavels Gordins, MD FRCPath**

Consultant Immunologist

**Sujoy Khan, MBBS FRCP FRCPath**

Consultant Immunologist

**Immunology Specialist Nurses:** Jackie Moor, Beverley Fish, Rebecca Avison, Sarah Sholtysek

**Immunology Secretaries:** Sarah Dawson, Faye Youhill, Siobhan Corlass

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**Suspected Peri-operative Anaphylaxis Referral Form**

**Patient Details:**

Name

Date of Birth Hospital/NHS number

Address

Telephone

**Referring Anaesthetist/Clinician:**

Name

Address

Contact telephone number Fax

Email

**Surgical Consultant at time of event:**

**GP:**

Name

Address

Contact telephone number Fax

**Date of Reaction:** .…../……/….… **Time of Reaction** (24 h clock)**:**  .…. : .….

**Suspected cause of the reaction:**

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

**Timing of reaction:**

*Induction Intra-operatively Recovery*

**Proposed Surgical Procedure:** ………………………………………………………………………

**Was surgery completed?**  [ ]  Yes [ ]  No **If no, is surgery urgent?** [ ]  Yes [ ]  No

**Reaction Details:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Symptom/Sign** | **Present** (tick box) | **Onset Time** (24h clock) | **Time Resolved** (24h clock) | **Severity** (Mild/Moderate/Severe) |
| Hypotension | [ ]  |  |  | Lowest BP |
| Tachycardia | [ ]  |  |  |  |
| Bradycardia | [ ]  |  |  |  |
| Bronchospasm | [ ]  |  |  |  |
| Cyanosis or Desaturation | [ ]  |  |  | Lowest SpO2 |
| Angioedema | [ ]  |  |  |  |
| Urticaria | [ ]  |  |  |  |
| Arrhythmia | [ ]  |  |  | Rhythm |
| Flushing | [ ]  |  |  |  |
| Itching | [ ]  |  |  |  |
| Other (specify) |  |  |  |  |
| Other (specify) |  |  |  |  |

**Skin preparation for surgery:** ………………………… **Time** (24h clock)**:** ……………

**Time surgery commenced** (24h clock)**:** ……………………………

**Time surgery stopped/completed** (24h clock)**:** ………………………..

**Procedures performed BEFORE the onset of the reaction:** (Intubation or LMA, peripheral nerve or neuraxial blockade, CVC insertion, urethral catheterisation with or without local anaesthetic etc.)

Neuraxial blockade

Spinal [ ]  Epidural [ ]  Epi-spinal [ ]

|  |  |  |
| --- | --- | --- |
| Drug/Procedure | Time (24 hr clock) | Route |
|  |  |  |
|  |  |  |

Peripheral nerve/regional block

Type of block(s) .........…………………………

|  |  |  |
| --- | --- | --- |
| Drug | Time (24 hr clock) | Route |
|  |  |  |
|  |  |  |

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 given BEFORE the onset of the reaction** (including intravenous fluids)**:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug** | **Time** (24h clock) | **Time over which given**(‘STAT’ or in min:sec) | **Route** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

**Drugs given AFTER the onset of the reaction** (including intravenous fluids)**:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug** | **Time** (24h clock) | **Time over which administered**(‘STAT’ or in min:sec) | **Route** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

**Response to treatment:**

**HDU/ICU post event?**  [ ]  Yes [ ]  No

**Have tryptase levels been sent?**[ ]  Yes [ ]  No

*Immediate Date…….. Time…….. Value……..*

*Peak (1 to 3 hrs post event) Date…….. Time…….. Value……..*

*Baseline (>24 hrs post event) Date…….. Time…….. Value……..*

*N.B. It is the responsibility of the referring anaesthetist or clinician to obtain the results from the laboratory*

**Any additional information:**

**N.B. The completed form should be accompanied by photocopies of:**

* Anaesthetic record and any previous anaesthetic records;
* Prescription record;
* Recovery room documentation;
* Any relevant ward documentation;
* Any other relevant documents including blood test reports (incl. tryptase values).

*Please file a copy of this form in the patient’s casenotes and keep a copy for your own records.*

**Please send the completed form to:**

|  |  |
| --- | --- |
| Dr Pavels Gordins/Dr Sujoy Khan **OR**Consultants in Immunology and AllergyDepartment of Immunology and AllergyQueen’s CentreCastle Hill HospitalCastle RoadCottinghamEast Riding of YorkshireHU16 5JQDirect Dial: (01482) 461312 / 61297Email: sarah.dawson26@nhs.net faye.youhill@nhs.net | Dr Caroline HibbertConsultant AnaesthetistDepartment of AnaesthesiaCastle Hill HospitalCastle RoadCottinghamEast Riding of YorkshireHU16 5JQDirect Dial: (01482) 675031 Email: caroline.hibbert4@nhs.net |