

Suspected Perioperative Allergic Reactions – Referral Proforma for Allergy Investigation and Consultation

To refer a patient for investigation of a possible allergic reaction during anaesthesia, please complete this form and send to the relevant immunology or allergy department. (Appendix A). An electronic completed proforma is accepted in some centres as a preliminary notification, however the patient will not be seen unless the referral is completed.

The form should be completed by the anaesthesiologist involved in the case and must be accompanied by the following documents:

- Pre-op Drug Kardex
- Copy of Anaesthetic notes (including induction and vital signs)
- Copy of operative notes
- Drug Kardex: post-operative (including drugs given in ITU & any drug infusions)
- Notes from assessment of acute reaction and resuscitation

The discharge summary (from ITU/HDU and from ward) is required before the patient is seen, but should not delay referral.

Accurate timing of administration of medications relative to onset of symptoms is important in choosing which medications and other exposures should be tested, and also is essential when interpreting results. Please provide accurate times when available. If the actual time is not known, and an approximate time is provided, please mark the medication(s) as approximate on the list of administered drugs.

In the immediate aftermath of an anaphylactic reaction, skin testing is unreliable as mast cells are depleted. The optimal time for assessment of perioperative anaphylactic reactions is 4-6 weeks following the reaction. If surgery is required urgently, discussion with the Consultant leads for the service to which you plan to refer is recommended.

Section 1: Contact details

It is essential that we can contact the Anaesthesiologist to clarify details to ensure that testing can proceed within the recommended time frame. **This information is required, even for preliminary notification.**

Referring Consultant Anaesthesiologist:

Name: _____ Hospital: _____

Mobile No: _____

Email:(Secure email preferred) _____

Patient details

Patient GP Details:

Operating Consultant Details:

Patient phone number _____

Secure email _____

Section 2: Patient Past Medical History

Previous Respiratory disease _____

Previous Cardiovascular disease _____

Diseases affecting other systems _____

Regular medications (incl. dose; please add extra sheet if additional space needed)

Prior history of drug/chlorhexidine allergy: _____

Previous Anaesthetic History:

Date/Hospital				
Uneventful?	Y/N	Y/N	Y/N	Y/N
Drugs given				
Fluids				

Patient Name:

DoB or MRN:

Section 3: Reaction details

Date of reaction _____ Proposed operation _____

Was surgery completed? Yes / No

Suspected agent (if any) _____

Referring clinician's assessment:

Definite Allergy / Probable Allergy/ Possible Allergy / Allergy unlikely

If allergy unlikely, what alternative explanations are being considered:

Time of onset of symptoms (24hr clock).

Initial observations

BP:___/___mmHg HR _____bpm Sats_____ % FiO₂___% or _____LO₂

Severity of reaction

tick one

- Cutaneous signs only
- Measurable signs *e.g.hypotension (fall >30%) tachycardia*
- Life-threatening *e.g. circulatory collapse or severe bronchospasm*
- Cardiac/ Respiratory arrest

Symptom/ Sign	Time of onset	Time resolved
Hypotension		
Tachycardia		
Bronchospasm		
Cyanosis/ desaturation		
Angioedema		
Urticaria		
Arrhythmia		
Other (specify)		

Patient Name:

DoB or MRN:

Description of Reaction

(include any information you feel is important)

Section 4. Medications and other exposures

Outline any procedure which was undertaken prior to onset, such as placement of lines, arterial, CVC or urinary catheters, cardiopulmonary bypass or any other instrumentation.

Patient Name:

DoB or MRN:

Premedication drugs (please ensure Kardex is attached)

Drug	Dose	Route	Time (24 hr Clock)

Induction Drugs and drugs given at induction

Please fill in the tables below. If the agent was not used, please write N/A or cross out agent on list. Please fill in name of neuromuscular blocking agent (NMBA), antibiotic, dye, local anaesthetic or 'other' medication, if applicable. Please use Block Capital letters.

Agent	Dose	Route of Administration	Time(s) Administered (24hr clock)	Given uneventfully afterwards?
Propofol				Yes / No
NMBA:				Yes / No
NMBA:				Yes / No
Analgesic:				Yes / No
Analgesic:				Yes / No
Ondansetron				Yes / No
Dexamethasone:				Yes / No
Midazolam:				Yes / No
Antibiotic:				Yes / No
Antibiotic:				Yes / No
Other:				Yes / No
Other:				Yes / No

Maintenance drugs (including volatile agent), analgesics and drugs to reverse neuromuscular blockade

Agent	Dose	Route of Administration	Time(s) Administered (24hr clock)	Given uneventfully afterwards?
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
Sugammadex				Yes / No

Patient Name:

DoB or MRN:

Other medications and exposures: (including those given/used by operating surgeon or proceduralist). Please mark as N/A if not administered:

Agent	Dose	Route of Admin	Time(s) Administered (24hr clock)	Given uneventfully afterwards?
Chlorhexidine				Yes / No
Betadine				Yes / No
Latex				Yes / No
Instillagel				Yes / No
Gelofusin				Yes / No
Intra-operative contrast:				Yes / No
Intraoperative dye:				Yes / No
Antibiotic:				Yes / No
Antibiotic:				Yes / No
Paracetamol				Yes / No
NSAID:				Yes / No
Local anaesthetic:				Yes / No
Heparin:				Yes / No
Chlorhexidine coating on lines etc				Yes / No
Eye Drops				Yes / No
Blood products				
Other:				Yes / No
Other:				Yes / No

Regional Anaesthesia – include ANY exposure to local anaesthetic.

Regional Technique _____

Agents used for regional anaesthesia

Agent	Dose	Route of Administration	Time(s) Administered (24hr clock)	Given uneventfully afterwards?
				Yes / No
				Yes / No
				Yes / No
				Yes / No

Patient Name:

DoB or MRN:

Section 4: Blood Sampling for Tryptase

Recommended timing of mast cell tryptase samples:

Serum or serum gel tube usually required.

First sample *Once patient is stable. (Ideally within 30 minutes)*

Second sample *1 to 2 hours post reaction. (No more than 6 hours)*

Third sample *At least 24 hours post event.*

Laboratory processing tryptase samples St James' / Beaumont / Galway / Other
(specify) _____

Time and date of blood sample 1 _____ Result (if available) _____

Time and date of blood sample 2 _____ Result (if available) _____

Time and date of blood sample 3 _____ Result (if available) _____

Additional Clinical Details:

Does the patient require surgery again on an urgent basis?

Yes

No

If testing is positive for NMBA used during the procedure, what are the alternative NMBAs most suitable for use in this patient for any anticipated surgery?

Appendix A:

Referrals can only be accepted with complete documentation. Incomplete referrals will be placed on hold, pending receipt of the required documentation. However, when patients require urgent surgery, preliminary information in the form of a completed proforma can be submitted, in advance of the supporting documents to allow appointment planning.

Paediatric Cases (<16 years)

Dr Aideen Byrne/Dr Maeve Kelleher
Allergy Department
CHI at Crumlin
Dublin 12
Phone: 01-4096013
Email: allergy.secretary@childrenshealthireland.ie

Paediatric Cases (<16yrs) Cork University Hospital

Dr Juan E. Trujillo Wurttele
Paediatric Allergy
Cork University Hospital
Phone: (021) 4922200
Email: juan.trujillo@hse.ie

Adult Cases (≥16 years)

Dr Khairin Khalib / Prof Mary Keogan/ Dr. Fionnuala Cox – for urgent discussion if required, contact via Beaumont switch (01-809 3000)
Dept of Immunology
Beaumont Hospital
Beaumont,
Dublin 9.
Phone 01-809 3026
Email: immunologydepartment@beaumont.ie

Adult cases (≥16 years)

Prof Niall Conlon/ Prof David Edgar/Dr Salma Alamin
Dept. of Immunology
St. James Hospital
Dublin 8.
Phone (01) 410 2928
Email: immunologymail@stjames.ie

Galway University Hospital

Adult cases (≥16 years)

Prof Vincent Tormey/ Dr Cariosa Lee-Brennan
Dept. of Immunology
Galway University Hospital
Galway
Phone 091-543401/893970

Paediatric Cases (<16 years)

Dr Edina Moylett
Department of Paediatrics
Galway University Hospital
Galway
Phone 091-868454