**THIS FORM SHOULD BE COMPLETED (PREFERABLY TYPED) BY A SENIOR ANAESTHETIST**

**Patient details**

Name……………………………………………………………......................................................

Date of birth …./…./…….. Hospital / NHS Number …………………………………...

Address …….………………………………………………………...............................................

…………………………………………………… Telephone ……………................……………...

**Referring consultant anaesthetist (for clinic correspondence)**

Name……………………………………………………………………………..….………………....

Address…………..………….………………………………………………………………...............

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

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

Name……………………………………………………………………………..….………………....

Address…………..………….………………………………………………………………...............

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

**Surgeon (for clinic correspondence)**

Name……………………………………………………………………………..….………………....

Address…………..………….………………………………………………………………...............

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

**Date of the reaction.…./…../20....**

**Time of onset of Clinical Features ….../…...h (24h clock)**

**Suspected cause of the reaction (most likely first)**

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

**Proposed surgical 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.…………………………………………………………….........

**TIMELINE 1: Drugs administered in the hour before the reaction. Please include any other relevant exposures, e.g. chlorhexidine, iv colloids, Patent Blue dye**

|  |  |  |  |
| --- | --- | --- | --- |
| **Drugs and other exposures** | Time (24 hour clock)  | Route of drug administration | Comments |
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Please add lines or continue on a separate page if you need to add more details

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 ....................

**TIMELINE 2: Clinical features of the reaction and other relevant events. Please include lowest BP, SpO2 and exhaled CO2.**

|  |  |  |  |
| --- | --- | --- | --- |
| Symptom/ Sign | Onset Time(24 h clock)  | Time resolved (24 h clock)  | Severity (Mild/Moderate/Severe) |
| Hypotension |  |  | Lowest BP / mmHg |
| Tachycardia |  |  |  |
| Bradycardia |  |  |  |
| Bronchospasm |  |  |  |
| Cyanosis/ desaturation |  |  | Lowest SpO2 |
| Angioedema |  |  |  |
| Urticaria |  |  |  |
| Arrhythmia |  |  |  |
| Flushing |  |  |  |
| Itching |  |  |  |
| Other (specify) |  |  |  |

Please continue on a separate page if you need to add more details

**PLEASE GIVE A SHORT CLINICAL NARRATIVE OF PERIOPERATIVE EVENTS**

**TIMELINE 3: Drugs and IV fluids given to treat the reaction**

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug /IV fluid**  | **Time (24 hour clock)**  | **Route**  | **Comments on response to treatment** |
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Please continue on a separate page if you need to add more details

**CPR REQUIRED? Yes** [ ]  **No** [ ]  **Time started ….../…...h (24h clock)**

**Duration of CPR (minutes) ........................**

**ADVERSE SEQUELAE from this reaction e.g. cardiac, renal, neurological, respiratory, anxiety**

**...........................................................................................................................**

**...........................................................................................................................**

**...........................................................................................................................**

**Investigations performed prior to referral (please give results)**

**N.B. It is the anaesthetist’s responsibility to obtain the results from the laboratory**

Were blood samples taken for Mast Cell Tryptase? Yes [ ]  No [ ]

First MCT sample Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result……..........…….

Second MCT sample Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result………..............

Third MCT sample Time\_\_\_:\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_ Result…..........……….

Other bloods 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 ...................................

Send completed form and copy of the anaesthetic chart / monitoring information via

e-mail to allergyappointments@heartofengland.nhs.uk

& copy to angela.mckenna-hylton@heartofengland.nhs.uk

* **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**

REFERRALS WILL BE ACCEPTED ONLY WHEN THE COMPLETE INFORMATION IS RECEIVED.

*Please file a copy of this form in the patient’s casenotes*