**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](mailto:allergyappointments@heartofengland.nhs.uk)

& copy to [angela.mckenna-hylton@heartofengland.nhs.uk](mailto: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*