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# Part Three: Administering Xolair

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## Patient Consent Form

### **Consent to Xolair Administration Program**

1. I authorize the Dean Medical Center and its medical staff to perform the necessary Xolair injections for myself, a minor child or another person for whom I have authorization to sign.
2. The following information has been discussed with me:
  - a. The nature and purpose of the Xolair treatment program
  - b. The risks of the treatment including the possibility of an allergic reaction as well as the risk that the treatment program may not accomplish the desired objectives
  - c. The possible outcome of the treatment
  - d. The available alternative medical treatments
  - e. The prognosis if the program is not followed
  - f. The need for regular therapy and follow-up including the need to evaluate my asthma by keeping records of my medication use, symptoms and need for unscheduled care. (This may be done by mail-in forms, telephone, computer, pharmacy records or similar means)
3. I have had sufficient opportunity to discuss my condition with my allergist, and all of my questions have been answered to my satisfaction. I have read and understand the Xolair Treatment Information Form. I believe that I have adequate knowledge upon which to base an informed consent to this program.
4. I consent to other diagnostic and therapeutic procedures and the monitoring program that the physician decides might be necessary due to unexpected conditions (such as treatment of an allergic reaction).
5. I am aware that the practice of medicine is not an exact science, and no guarantees have been made to me concerning the results of this program.
6. I have read and fully understand this consent form.

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Signature of patient/other

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Date signed

\_\_\_\_\_  
If other, relationship to patient

\_\_\_\_\_  
Witness