



# REFERRAL FORM

**PATIENT LABEL**

Surname: \_\_\_\_\_

Given Names: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Record Number: \_\_\_\_\_

**Hand print patient name**  
*Please check patient name, address and phone number on label are correct*

Patient's Email: \_\_\_\_\_

Home phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

**Referring Doctor (name):** \_\_\_\_\_

Provider Number: \_\_\_\_\_

Position:      Anaes consultant      Anaes Registrar      GP Anaesthetist      Other

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Postal address: \_\_\_\_\_

**Patient Medical History**  
*Please tick relevant conditions:*     Pregnant     Asthma     Eczema     Hay fever

Drug Allergy (specify) \_\_\_\_\_

Food Allergy (specify) \_\_\_\_\_

Other Allergy (specify) \_\_\_\_\_

Other Medical History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medication**  
*Tick where patient taking:*     Oral steroids     Antihistamines      $\beta$ blockers     Antidepressants  
 ACE Inhibitors/AII Receptor antagonist     NSAID

List medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Hospital where reaction occurred: \_\_\_\_\_

Procedure: \_\_\_\_\_

Date of reaction (dd/mm/yyyy): \_\_\_\_\_ Date of referral (dd/mm/yyyy): \_\_\_\_\_

Time of induction (HH:mm): \_\_\_\_\_ Time reaction first noted (HH:mm) \_\_\_\_\_

Type of Anaesthesia:  General  Regional  Local  IV sedation

***The patient was exposed to the following medications PRIOR to the reaction(indicate time of exposure):***

Agent Administered	Time	Agent Administered	Time

***Please tick if the patient was exposed to the agents listed below (indicate time of exposure):*** Time

<input type="checkbox"/> Chlorhexidine	<input type="checkbox"/> wipes	<input type="checkbox"/> skin prep	<input type="checkbox"/> Other (specify):	
<input type="checkbox"/> Skin preparation	Type:			
<input type="checkbox"/> Latex	<input type="checkbox"/> Gloves	<input type="checkbox"/> Other (specify):		
<input type="checkbox"/> Contrast Agent	Type:			
<input type="checkbox"/> Methylene Blue	<input type="checkbox"/> Patent Blue			
<input type="checkbox"/> Colloid	Type:			
<input type="checkbox"/> Blood products	Type:			
<input type="checkbox"/> Antibiotics	Type:			
<input type="checkbox"/> Central venous line	<input type="checkbox"/> Chlorhexidine coated	<input type="checkbox"/> Antibiotic coated	<input type="checkbox"/> Other	
<input type="checkbox"/> Vaginal packing	Type:			
<input type="checkbox"/> Urinary catheter	Type:			
<input type="checkbox"/> Lubricant	Type:			
<input type="checkbox"/> Other				



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Symptoms & Signs of Reaction				
Tachycardia > 100bpm (before adrenaline administered)	Yes	No		
Bradycardia <60bpm	Yes	No		
Arrhythmia	Yes	No	Type:	
Cardiac arrest	Yes	No		
Hypotension	Yes	No	Time with systolic < 60mmHg	mins
Cough	Yes	No		
Bronchospasm	Yes	No	Mild wheeze	Dyspnoea reported by patient
			Moderate wheeze	Difficult to ventilate
			Severe wheeze	Very difficult to ventilate
Low oxygen saturations	Yes	No	<input type="checkbox"/> SpO2 80-90	<input type="checkbox"/> SpO2 <80
Flushing/erythema	Yes	No	<input type="checkbox"/> Localised or	<input type="checkbox"/> Generalised
Urticaria	Yes	No	<input type="checkbox"/> Localised or	<input type="checkbox"/> Generalised
Piloerection	Yes	No		
Angioedema	Yes	No		
Swelling	Yes	No	Site	
			Duration	
Other cutaneous signs	Yes	No	Specify:	
Gastrointestinal signs	Yes	No	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
			<input type="checkbox"/> Abdominal cramps/pain	
			<input type="checkbox"/> Other _____	
What was the first symptom you noticed?				
What was the predominant symptom?				
<i>Comments:</i>				



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**Details of Treatment**

**Airway Management**

Assisted/Mechanical Ventilation  Yes  No  Planned  Unplanned

Endotracheal intubation  Yes  No  Before onset  After onset

Bronchospasm treatment?  Yes  No  
 Specify agent/s used & dose:

Adrenaline given?  Yes  No  IV  IM  SC  ETT  
 Total dose administered: \_\_\_\_\_ mcg

IV Fluids given for resuscitation?  Yes  No  
 Specify type/s of fluid & total volume:

Cardiac compressions? Yes No How long was CPR performed?: \_\_\_\_\_ mins

Cardioversion/Defibrillation Yes No Number of shocks: \_\_\_\_\_

Vasopressors other than adrenaline given?  Yes  No

Ephedrine Dose \_\_\_\_\_ mg  Metaraminol Dose \_\_\_\_\_ mg  
 Vasopressin Dose \_\_\_\_\_ Units  Phenylephrine Dose \_\_\_\_\_ mg  
 Noradrenaline Dose \_\_\_\_\_ mg  Methylene Blue Dose \_\_\_\_\_ mg  
 Other (specify): \_\_\_\_\_

Steroids given?  Yes  No  
 Specify steroid used & dose:

Antihistamines used?  Yes  No  
 Specify antihistamine used & dose:

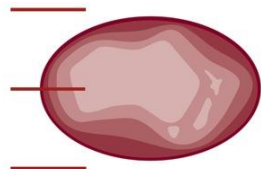
Did you use the ANZAAG Anaphylaxis Management Resource?  Yes  No  
*Please comment on any ways in which you think the resource was helpful or could be improved:*

\_\_\_\_\_

\_\_\_\_\_

*Other treatments/Comments:*

\_\_\_\_\_



**ANZAAG**  
Australian & New Zealand  
Anaesthetic Allergy Group

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## Investigations

Serum tryptase taken?  Yes  No

Recommended to take 10ml samples 1-2 hours, 4 hours and more than 24 hours after reaction:

*Please record time samples taken and attach results to this referral (where available)*

Sample 1: Time \_\_\_\_\_ Result: \_\_\_\_\_ mcg/L  Sample 3: Time \_\_\_\_\_ Result: \_\_\_\_\_ mcg/L

Sample 2: Time \_\_\_\_\_ Result: \_\_\_\_\_ mcg/L  Sample 4: Time \_\_\_\_\_ Result: \_\_\_\_\_ mcg/L

Which pathology laboratory were the specimens sent to?

Is there a differential diagnosis other than anaphylaxis that you think may have caused the reaction?

Comments:

## Outcome/Sequelae

Operation/procedure completed or  Operation/procedure abandoned

Patient transferred to PACU/recovery?  Yes  No

Was the patient admitted to hospital?  Yes  No  Tick if admission unplanned

Postoperative care in ICU/HDU?  Yes  No

If yes: Was the patient still intubated/ventilated on transfer? Yes No Duration

Was an inotrope infusion continued? Yes No Duration

How long was the patient in ICU?

Were there any further complications?

ECG Changes  Coagulopathy  Troponin rise  Pneumothorax  Anxiety/PTSD

Other

## Severity of Allergic Reaction

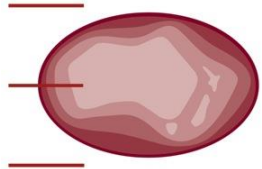
Please specify the Grade of Allergic Reaction from the categories below:

**Grade I – cutaneous-mucous signs:** erythema, urticaria with or without angioedema

**Grade II – Moderate multivisceral signs:** cutaneous-mucous signs +/- hypotension +/- tachycardia +/- dyspnoea +/- gastrointestinal disturbance

**Grade III – Life-threatening mono- or multivisceral signs:** cardiovascular collapse, tachycardia or bradycardia +/- cardiac dysrhythmia +/- bronchospasm +/- cutaneous-mucous signs +/- gastrointestinal disturbance

**Grade IV – cardiac arrest**



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**Comments:**

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\_\_\_\_\_

***Please tick to acknowledge that you are aware of the following:***

You are responsible for forwarding this referral and supporting documents listed to your nearest or preferred ANZAAG member. A contact list of testing specialists can be found at [www.anzaag.com](http://www.anzaag.com)

A copy of the resuscitation/anaesthetic/PACU charts and tryptase results (where available) must accompany this referral.

The correct patient details have been supplied to allow follow up with the patient.

The patient is aware of the events and this referral. The patient information brochure available at [www.anzaag.com](http://www.anzaag.com) may assist with this discussion.

The patient has a letter listing all substances administered perioperatively to show to those providing care until testing can be conducted. A form letter is available at [www.anzaag.com](http://www.anzaag.com) to assist in this process.

***Referrer Signature:***

\_\_\_\_\_