

**Procedure for the Notification and Initial Investigation of Suspected Anaphylaxis**

<b>Name</b>	
<b>Date of Birth</b>	
<b>Hospital No</b>	
Place addressograph here	

<b>Date of reaction</b>	
<b>Time anaesthetic started</b>	
<b>Time of reaction</b>	
<b>Referring doctor</b>	
<b>Referring Hospital</b>	

Arrange blood sampling as follows:

- Serial 5ml clotted venous blood samples collected at the following times:

<b>Sample 1</b> <i>Within 1 hour of reaction</i>	<b>Sample 2</b> <i>3-6 hours post-reaction</i>	<b>Sample 3</b> <i>24 hours post-reaction</i>
Time:	Time:	Time:

- Store samples in theatre fridge until all samples are collected.
- Send samples accompanied with this form to:

**Dr Alistair Crockard**  
**The Regional Immunology Service**  
**Kelvin Laboratories**  
**Royal Group of Hospitals Trust**  
**Grosvenor Road**  
**Belfast BT 12 6BA**

- Notify referral to Regional Immunology Service, RGH  
**Telephone: 028 9063 3853 / 028 9063 2669 or Fax: 028 9063 2622**
- **PLEASE GIVE DETAILS OF THE REACTION AND PATIENT'S MEDICAL HISTORY BY COMPLETING THE REMAINDER OF THIS FORM (OVERLEAF).**

Nature of surgery	
Was surgery completed?	
Has surgery been re-scheduled? (Please estimate expected date of future surgery)	

Past medical history	
Allergy history	
Regular prescribed medication	

Details of reaction: *(Please complete those values you can recall)*

Signs and Symptoms	Severity <i>(Please circle)</i>				
Rash	Mild flushing along vein			Urticarial rash on trunk/limbs	
	Generalised flushing			Other <i>(Please specify)</i>	
Tachycardia	Mild	Moderate	Severe	Highest HR	
Hypotension	Mild	Moderate	Severe	Lowest BP	
Bronchospasm	Mild	Moderate	Severe	Highest airway pressure	
Cardiac Arrest	YES	NO		Respiratory Arrest <i>(If not using relaxants)</i>	YES      NO
Any other comments about reaction:					

Please tick those agents to which the patient was exposed during the procedure. Use the spaces provided to add any other agents used including antibiotics and local anaesthetics

Propofol	<input type="checkbox"/>	Morphine	<input type="checkbox"/>	Suxamethonium	<input type="checkbox"/>	Rocuronium	<input type="checkbox"/>		
Thiopentone	<input type="checkbox"/>	Fentanyl	<input type="checkbox"/>	Atracurium	<input type="checkbox"/>	Vecuronium	<input type="checkbox"/>		
Etomidate	<input type="checkbox"/>	Alfentanil	<input type="checkbox"/>	Cisatracurium	<input type="checkbox"/>	Gelofusine/ Volplex	<input type="checkbox"/>		
Ketamine	<input type="checkbox"/>	Remifentanil	<input type="checkbox"/>	Mivacurium	<input type="checkbox"/>	Voluven	<input type="checkbox"/>		
Midazolam	<input type="checkbox"/>	Pethidine	<input type="checkbox"/>	Pancuronium	<input type="checkbox"/>	Haemacel	<input type="checkbox"/>		
Chlorhexidine <i>(Please circle)</i>	YES	NO							