John Leung MD
Boston Food Allergy Center
65 Harrison Ave, Suite 201, Boston, MA 02111
Tel: (617) 804-6767 Fax: (877) 726-8492

Name
DOB:
MRN:

Appendix 5: Pre-OFC Package

Instructions for Food Challenge

Preparing for a Food Challenge
5 days before challenge:
Stop any oral antihistamine medications. This includes Zyrtec (cetirizine), Benadryl (diphenhydramine), Claritin (loratidine), Allegra (fexofenadine), and Atarax (hydroxyzine), but there are many others, as well, so read all medication labels carefully, especially over-the-counter allergy/sinus/cold medications. If you have any questions, or if you take any of these medications within 1 week of the challenge, please contact our clinic.

If you have asthma, please continue your daily inhaled steroid medications for asthma (Flovent, Advair, Pulmicort, Symbicort, Asmanex) and/or Singulair.
If you use albuterol, Xopenex or any bronchodilator medication more than two times (except prior to exercise) in the week before the food challenge, please contact our clinic.

You can continue inhaled steroid nasal sprays (Flonase, Nasonex, Rhinocort), but please
Stop antihistamine nasal sprays (Astelin, Astepro).

Day of the Challenge
You can have only clear liquids (e.g., water, fruit juices that have no pulp, sports drinks, popsicles) for 2 hours prior to the challenge.

Please bring your auto-injectable epinephrine (Epi-Pen, Auvi-Q, or Twinject) to the appointment to have available after you have left the clinic. This is a precaution in case a delayed reaction occurs after leaving the clinic.

Please arrive on time. Food challenges are quite slow in order to progress from a minute amount of the food being tested to a full portion, and to closely monitor for a potential reaction. During the challenge, vital signs, oxygen saturation, breath sounds, and skin assessments will be performed regularly. We will also ask you to note any signs or symptoms that you observe and report them immediately to us.

You will be in the clinic for several hours. Please bring something to occupy yourself such as a laptop, book, IPOD, etc.

During the challenge, no other food should be ingested.

If you have any symptoms during the challenge, we would advise continued avoidance of the offending food.

Following the food challenge, you will be given specific recommendations depending upon the outcome of the challenge.

Please do not hesitate to call our clinic for any questions or concerns: 617-804-6767

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Oral Food Challenge Appointment

You have been scheduled for a food challenge on ____/_____/_____at _____am/pm
at the (location) _____.

Please do not be late. We reserve the right to cancel the appointment if you are late.

Stop all antihistamines on _____(5 days before food challenge).

The food being challenged is _____

Please bring: (food being challenged) _____

Please ensure that bring food that does not have any cross-contamination with other foods.

Amount of food that you should bring:_____

Special preparation instructions: None

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Oral Challenge Agreement Form

On your next appointment, you are scheduled for an oral challenge. Oral challenges are very involved appointments that use a lot of resources and time. We ask that when scheduling this appointment, you please confirm that you will be attending it. Patients often wait very long for these appointments, so we ask that if you are not able to make the appointment, you let us know as soon as possible. Please fill out and sign the form below.

(Patient's First, Last)_____ has been scheduled for an oral challenge with Dr. John Leung on _____, 20 at _____ (am/pm).

I, _____ (parent or guardian ages 18 and over), understand the importance of my attendance at this appointment. I understand that a staff member will call me up to eight days before the oral challenge, and that if I cannot confirm this appointment within **24** hours, than we may not be able to be seen. You may also call us to confirm at 617-804-6767.

Name (printed):_____ Date of Birth:_____

Signature: _____ Date: _____

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Appendix 6: Protocol Sample

Challenge Food: _____

☐ Patient has been practicing strict avoidance or other: _____

Date of last reaction: _____ Symptoms: _____

Date of total IgE level: _____ Total IgE level (IU/ml): _____

Date of sIgE: _____ sIgE (Ku/L): _____

Date of PST: _____ PST (mm): _____

☐ Asthma Asthma control: _____

☐ Eosinophilic Esophagitis Other Food Allergies_____

☐ Atopic Dermatitis Exacerbated by food?_____

Protocol: Every 15 minutes

Steps	Percent	Amount
1	1%	
2	3%	
3	10%	
4	30%	
5	56%	
	Total dose	

See flow sheet for standard symptoms flow sheet with 20 minute intervals and 1 hour observation period.

Provider Signature/Print: _____Date: _____