Dermatology
UNIVERSITY OF COLORADO **MEDICINE**

Hello,

Thank you for choosing the Patch Test Clinic at University of Colorado Medicine Dermatology.

We have provided an informational packet for what to expect at your time of visit as well as a questionnaire to help us coordinate your care.

Our address is 14305 E Alameda Avenue, Suite. 225, Aurora, CO 80012 (in the Westerra Credit Union Building). A map is enclosed for your convenience. Should you have any questions please do not hesitate to contact our office at 303-315-5085.

Sincerely,

CU Dermatology Aurora
Patch Test Clinic

DUE TO COVID:

- We ask you to bring your mask. It is mandatory to wear your mask during your visit.
- Please call us at 303-315-5085 upon your arrival and we will instruct you on when to come in.
- If available, please do the check-in process via MHC (My Health Connection).

Please fill out NEW PATIENT PAPERWORK and return via email or fax five (5) days before your appointment.

CU Dermatology Patch Testing is located at 14305 E Alameda Ave, Suite 225 (2nd floor). Our clinic is conveniently located just off Alameda Avenue near I-225, in the Westerra Credit Union building.

We are located across the street from Chick-Fil-A. Entrance is located directly east of Raising Canes.

Patient parking is free.

Please feel free to call 303-315-5085 with any questions or if you need to reschedule your appointment.

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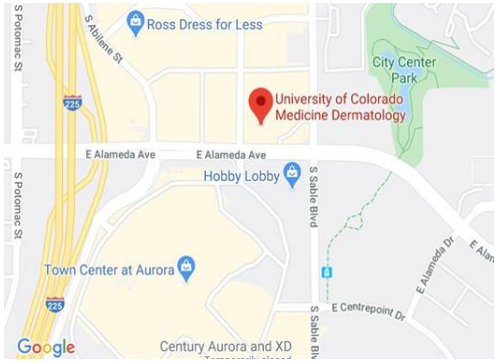
CHECKLIST FOR PATCH TESTING

- **REGISTER with www.uch.edu/myhealthconnection. Update your health profile and medications.**
- Fill out and bring **ENTIRE/COMPLETED** Packet.
- Bring insurance cards.
- If you have prior patch testing results or skin biopsy reports, please bring those with you.
- Bring all **Products** used in area of rash over the past 3 months.
- Wear an old, dark T-shirt to visit (for young kids, it is a good idea to wear a T-shirt that is 1-2 sizes too small to help keep the patches snuggly in place).
- No tanning on your back 2-3 weeks prior to visit.
- No **STEROIDS** by mouth 1 week prior to visit. No topical **STEROID** creams to back for 3 weeks prior to visit (everywhere else is ok).
- No topicals of any kind on your back on the **Day** of your visit.
- Please shave your back if it is hairy.
- Once patches are applied, there is no reaching, stretching. or pulling. Patches must remain in contact with your back for **48** hours.
- Refer to **MAP** for our location.
- Plan to be at our clinic for two hours.
- **Once you have read through your packet and gone through your checklist if you have any additional questions please call the office.**
- **PLEASE** come prepared as you want your testing to be complete and you only want to do it once.



CU Patch Testing
University of Colorado
14305 E Alameda Ave. | Suite 225 | Aurora, CO 80012
P: 303.315.5085 | F: 303.315.5080

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PATCH TESTING: FREQUENTLY ASKED QUESTIONS

Why do I need patch testing?

- Patch testing helps to determine if you have allergies to things that touch your skin such as ingredients in skin care products.
- These ingredients may be found in your skin care products or in materials from home, hobbies, or work.
- Anyone can develop a contact allergy, from young children to adults.
- More exposure to an allergen increases your chance of developing an allergy.

What is patch testing?

- Patches are applied with tape (usually on the back) and these will need to stay in place for 48 hours (two (2) days).
- Patches should be removed and discarded after 48 hours.

Can I take a shower or exercise during patch testing?

- Exercise and shower before you arrive to clinic.
- Usually, we use waterproof tape so that you can take a quick shower even while the patches are taped in place.
- Avoid excessive sweating or exercise for 48 hours while the patches are in place.
- If you are lifting or stretching and you feel the tape pulling, then stop what you are doing.

What do I do if I have itching during patch testing?

- You may have some mild discomfort and itching on your back from the tape or possibly from a positive reaction to a test ingredient.
- Oral anti-histamines and cold-packs may be used to decrease itching during patch testing.

Do I need to stop my medications prior to patch testing?

- Notify the physician or nurse of any medications that lower your immune system, such as steroids, immunosuppressants, or biologics. You may need to stop the medication or lower the dose prior to testing.
- Do not apply topical steroids to the back for two weeks prior to testing.

Can I use lotion or tan prior to patch testing?

- Avoid any type of tanning on your back for two weeks prior to testing.
- Your back must be clear of rash, lotions, creams, and hair to complete the patch testing.
- If needed, shave your back the day before your patch testing.

What should I bring with me to the appointment?

- Bring skin care products that you have used in the area of rash over the past three months. It is helpful to bring them in their original containers or bring a copy of the ingredients contained in the product.
- Wear or bring a dark T-Shirt so that the pen marks outlining the patches do not stain your clothes.
- For younger children, it is helpful to wear a shirt that is 1-2 sizes too small to help keep the patches snuggly in place.

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COMPREHENSIVE CONTACT HISTORY FORM

Name:_____ DOB: _____
Referring Physician: _____ FAX:_____
Primary Care Doctor: _____ FAX: _____

RASH HISTORY:
Date of rash onset:

_____
Where on your skin did the rash first appear? _____

Describe rash (course, spread, frequency). Give dates._____
_____

1. Does the rash get better, worse, or stay the same on weekends or vacations from work?

_____
_____

2. When is the rash worsened or improved (seasons, stress)?

_____

_____

3. Have you ever been patch tested (list date and the results)?

_____
_____

4. Does your rash disturb your sleep?

_____
_____

5. Does your rash itch or burn (if yes, explain)?

_____
_____

6. Do you use ___hair dyes ___hair perms ___nail polish ___acrylic nails?

7. Is your rash aggravated by metal or jewelry, clothing or elastic, skin care products? Yes/ No
Explain:

_____
_____

8. Do you have animals? Yes/ No
What kinds? _____
How long have you had them? _____
Do they aggravate your rash? Yes/ No
Does your pet sleep with you? Yes/ No

9. Does touching food bother your skin (if yes, explain)? _____

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COMPREHENSIVE CONTACT HISTORY FORM (continued)

HOBBIES

What are your hobbies and how do you spend your free time (gardening, painting, working on cars or bicycles, etc.)?

_____

_____

_____

What products or substances do you touch when working at your hobby?

_____

_____

Do any of these products seem to aggravate your rash (if yes explain)

_____

_____

WORK HISTORY

Your job title:

_____

Describe what you do at work:

_____

How long have you worked in this occupation? _____

Has your job performance suffered since the onset of your rash (if yes, explain)? _____

_____

Are you unemployed or on medical leave of absence due to your rash? _____

Do other people at your work have the same type of rash (if yes, explain)?

_____

_____

Do you have any allergies? ☐ **YES** ☐ **NO**
Do you have a tape sensitivity? ☐ **YES** ☐ **NO** _____
If yes, what is the allergy and what was your reaction?

_____

_____

_____

Social History:

Marital Status _____

Number of Children and Ages _____

Medications, vitamins, Prescription skin products (may attach a separate sheet):

_____

_____

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COMPREHENSIVE CONTACT HISTORY FORM (continued)

Check the appropriate box if you or any of your family members have had any of the following conditions:				
	You	Mom	Dad	Other
Arthritis				
Asthma				
Eczema				
Heart Valve Replacement				
Immune Suppression				
Joint Replacement				
Psoriasis				
Seasonal Allergies				
Thyroid Disease				

Do you have any of the following symptoms or concerns?

	Yes	No		Yes	No
Abdominal Pain			Joint Aches		
Avoids sun exposure between 10am-4pm			Muscle Aches		
Chest Pain			Nasal Discharge		
Cough			Nausea		
Currently Nursing			Nosebleeds		
Currently Pregnant			Planning Pregnancy		
Depression			Shortness of Breath		
Diarrhea			Sore Throat		
Dizziness			Swollen Glands		
Easy Bleeding			Vomiting		
Feeling Tired			Weight Loss		
Fever			Worsening Vision		
Headache			History of Blistering Sunburns		

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Patient Registration and Insurance Waiver

□ Mr. □ Mrs. □ Ms □ Dr.

Patient_____ Today's Date _____
Last Name First Name MI

Address
_____
Street City State Zip

Birth Date____/____/_____Age_____Social Security #_____Home Phone _____
Cell Phone _____

Patient's Employer_____Work Phone _____

Patient's Occupation_____Marital Status □Single □Widowed □Divorced □ Married

Spouses Name_____Spouse's Employer _____

** **Person Responsible for Bill ****
Who is the person responsible for the Bill?____Self____Spouse____Child____Other Dependent

Name_____Social Security #_____
Last Name First Name
Address_____Phone#_____
Street City State Zip

1. **INSURANCE WAIVER:** I have requested services and/or therapies provided by CU Medicine. I understand I may be responsible for all charges incurred today for (service/opt code)_____by (provider) _____even if I elect to have my insurance billed first. Estimate of CU Medicine charges _____(**this is only an estimate and may not be the full financial responsibility**).

- The provider performing the above services or therapies is not a participating provider with my health insurance. Therefore, these services/therapies are not covered by my policy.
- The scope of services rendered by this provider may not be covered by my health insurance policy.
- The appropriate authorization required by my health insurance policy has not been obtained from my primary care physician. It is my personal decision not to obtain the authorization from my primary physician.
- **No claim will be sent to my insurance** since it is my personal decision not to use my health insurance benefits for the above service/therapy even though I understand that these services/therapies may be covered by my policy. (Elective Self Pay)

_____ _____
Patient Signature Date

(OR Parent/Guardian/Other Authorized Person if Patient is a Minor, Mentally Incompetent, Or Physically Unable to Sign this Form) _____
Witness to Signature

_____ _____
Print Name and Relationship of Person Authorized Reason Patient is Unable to Sign

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Health Information Exchange (HIE) Opt-Out/Opt-In Request Form

☐ I request that my health information not be viewable electronically through the University of Colorado Health System Information Exchange (HIE) system. I acknowledge that my information may still be transmitted as necessary to provide clinical care and for other purposes as required by law. I also understand that by opting out, my health information will not be available through the website in the case of an emergency.

I understand this request only applies to viewing my health information through the health information exchange system. I recognize that when I see a physician for treatment outside of the University of Colorado Health System that physician may request and receive my medical information from University of Colorado Health System through other methods permitted by law, such as fax, mail, or courier.

I am free to opt back in at any time and can do so by completing a Health Information Exchange (HIE) Opt-In Request Form that can be obtained from my health care provider.

A separate form must be filled out for each family member requesting to opt out.

☐ I previously submitted a request to "opt-out" of the Health Information Exchange (HIE) system and am now requesting to be reinstated so that my health information can be electronically accessible to authorized health care providers through the system.

A separate form must be filled out for each family member requesting to opt back in.

Patient First Name:	Middle Name:
Patient Last Name:	
Previous Names or Nicknames:	
Date of Birth (mm/dd/yyyy):	
Mailing Address:	
City, State, Zip Code:	
Contact Phone Number:	

_____ _____

Signature of Patient (or authorized representative) Signature Date
If under 18 years, signature of parent/guardian

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ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

By signing this document; I acknowledge that I have reviewed a copy of the University of Colorado School of Medicine and University Physicians, Inc. joint "Notice of Privacy Practices."

_____ _____
Name (Sign) Date

_____
Name (Print)

For Internal Use Only
Reason: Acknowledgement was not obtained:

_____
_____
_____
_____
_____

_____ _____
Name (Sign) Date

_____ _____
Name (Print) Date

Notice of Privacy Practices Acknowledgement-English 02/2019