Stinging Insect Allergy Evaluation/Testing/Treatment Questionnaire

This questionnaire is used for SM who **has already been screened positive** and **needs to be evaluated** by an allergist/immunologist

Section A: To Be Completed By Service Member

Name (Last, First, MI):		
DoD ID:	Last 4 SSN:	Contact phone number:
Service Member Signature:		Date:

1. Have you been screened for bee sting allergy? Yes □ No □
   If "No", stop here, complete STINGING INSECT ALLERGY SCREENING QUESTIONNAIRE
   If "Yes", go to question 2

2. Stinging insect allergy screening questionnaire positive (confirmed by a profiling provider)? Yes□ No□
   If "No", stop here. No further action is required.
   If "Yes", SM needs to see an allergist/immunologist to be tested and have the allergist/immunologist complete Section B

Section B: To Be Completed By Allergist/Immunologist

3. SM has a history of either a systemic reaction and/or a reaction of uncertain significance to stinging insect allergy. According to Policy 18-008, SM needs to be evaluated by an allergist/immunologist. Based on your assessments and specialty opinions, does this SM need testing? Yes □ No □
   If "No", stop here. Submit this questionnaire and all documentation to AR-MMC.
   If "Yes", complete questions 4 through 6 if applicable.

4. SM has allergy testing completed and the results are Positive □ Negative □
   If "Negative", stop here. Please submit the negative testing results, comments by an allergist/immunologist and all documentation to AR-MMC. No other further actions are required.
   If "Positive", SM needs to see an allergist/immunologist to complete a 3-year venom allergy shots.

Please note that one of following three scenarios indicates a negative result:
(1) Negative skin testing and negative serum specific IgE blood testing.
(2) Two negative skin tests, separated by six weeks.
(3) Negative serum specific IgE blood alone, if skin testing is contraindicated.

5. Has the SM started allergy shot therapy? Yes □ No □
   5a If "No," anticipated start date: _____
   5b If "Yes," date began therapy: _____ Anticipated completion date: _____
   5c If "Yes," Has SM reached desired maintenance dose? Yes □ No □
      5c(i) If "No," how long before SM is estimated to reach desired maintenance dose? ____
   5d If "Yes, is SM compliant with scheduled therapy? Yes □ No □

6. Has SM completed 3-years of allergy shot therapy? Yes □ No □
   6a If "Yes," does SM require further treatment? Yes □ No □
      6a(i) If "Yes", what is the estimated time for SM to complete further treatment?
      6a(ii) If "No", is SM required to carry an EpiPen? Yes □ No □
   6b If "No," which year of treatment is SM in? 1st □ 2nd □ 3rd □

Allergist/Immunologist: Full Name:	Specialty:
Medical Degree:	Full Signature:
Date of Evaluation:	Office Telephone Number:

SM: please submit the last year's venom allergy shots records (if already completed) along with this questionnaire completed by an allergist/immunologist to your AR-MMC case reviewer.