

UK Anaphylaxis Registry: Paper version for Case Report Form

This **Paper version of the UK Anaphylaxis Registry Case Report Form** can be used to collect de-identified data relating to a recent unintended allergic reaction to food or non-food trigger in the last 12 months. We are collecting all such events in adults and children, irrespective of whether the reaction was anaphylaxis.

Only ONE reaction should be documented per form. ALL fields are mandatory. Once completed, the data should be entered on to the Registry platform (anaphylaxie.net).

Please ask the patient (or parent/guardian) for verbal consent and to provide their email address: this is needed in order for them to receive a patient consent form and survey by email.

Patient Information

Healthcare Professional Information- Internal use

Date of reaction	Name and Surname
Patient age	Occupation
Sex at birth	Person entering data online
Verbal consent agreed (Yes/ No)	
Patient's email address	

Section 1. Information about the allergic reaction

1.1 What symptoms occurred? Please circle all that apply

Skin and mucosal	None	Angioedema (incl. swollen lips/ face) Erythema/ flush	Pruritus/ itch Conjunctivitis	Urticaria Unknown
Gastrointestinal	None	Abdominal pain/ cramps Abdominal distension	Diarrhoea Dysphagia	Nausea Faecal incontinence Vomiting Unknown
Respiratory	None	Rhinitis Dyspnoea/SOB Cough	Throat tightness Chest tightness Wheezing (expiratory)	Stridor Vocal hoarseness Laryngeal oedema Respiratory arrest Unknown
Cardiovascular	None	Dizziness Palpitations/ arrhythmia, Less alert (floppy in babies)	Loss of consciousness Hypotension (collapse) Chest pain/angina	Tachycardia Bradycardia Cardiac arrest Unknown
Other	Dysarthria Paraesthesia	Hotness Sight disorder	Sweating Feeling of impending doom	Trembling Tingling/burning of the hands/feet Cyanosis Pallor

1.2 What was the approximate time between allergen exposure and first symptoms?

1.3 Did a biphasic reaction occur? Yes No Unknown

If yes, please describe, using symptoms above:

How long after initial symptoms did further symptoms occur with biphasic reactions? (hours)

1.4 For fatal reactions only

Time from exposure to death:

Was treatment commenced prior to arrest?

Yes No Unknown

Was adrenaline used prior to arrest?

Yes No Unknown

1.5 Where was the patient at the time of the exposure?

In which country the reaction occurred: UK Abroad Unknown

Location where exposure occurred please describe (e.g. school, restaurant):

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1.6 Has the patient reacted to this allergen before? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
How many times has this allergen caused a reaction? <input type="text"/>	Was this reaction more or less severe than before? <input type="radio"/> Less <input type="radio"/> Same <input type="radio"/> More <input type="radio"/> Unknown
Which systems were affected? <i>Please circle all that apply:</i> Gastrointestinal tract <input type="checkbox"/> Skin <input type="checkbox"/> Cardiovascular system <input type="checkbox"/> Lower respiratory <input type="checkbox"/>	How long did the patient previously react to this allergen? <input type="radio"/> In the last 6 months <input type="radio"/> 6-12 months ago <input type="radio"/> 1-2 years ago <input type="radio"/> More than 2 years ago
1.7 Has the patient ever had anaphylaxis before (to any allergen)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

Section 2. Diagnostic testing

Has the patient had any diagnostic testing to the eliciting allergen? <input type="radio"/> Yes, before this reaction happened <input type="radio"/> Yes, but only since this reaction <input type="radio"/> No <input type="radio"/> Unknown					
What diagnostic tests have been done? <i>Choose one answer for each row</i>	<i>Not done</i>	<i>Test done:</i>	<i>Not known</i>		
	<i>+ve</i>	<i>-ve</i>	<i>known</i>		
Skin prick test (SPT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Has the patient ever had a baseline tryptase measured? <i>specify value (ng/mL)</i> <input type="text"/>
Challenge test (e.g. food, drug provocation)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Specific IgE: whole allergen extract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Did the patient know that they were allergic to the eliciting allergen prior to this reaction? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Specific IgE: recombinant allergen/component	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
CAST (cellular antigen stimulation test)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
IgG4 (venom exposition marker)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Intradermal test	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Basophil activation test	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Section 3. The eliciting factors

3.1 Is the suspected allergen known? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Reasonable suspicion
3.10 Is the elicitor known to be an occupational allergen for this patient? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

For food allergens only

3.2 Which food caused the reaction, describe: If non-prepacked, where was it bought? (e.g. Bakery, School, Supermarket) If prepacked product, was the brand known? <i>If yes, which brand:</i> If prepacked, was the food listed on the packaging? <input type="radio"/> Allergen listed as ingredient <input type="radio"/> No <input type="radio"/> Allergen listed as "may contain" <input type="radio"/> Unknown	Did the patient or person providing the food read the label (or other relevant information) before the food was eaten? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Who read the label? <i>Please circle one choice:</i> Patient / family / friend / catering / unknown member / staff
Estimated amount eaten, please describe (e.g. teaspoon, cup, plate, contact only): <input type="text"/>	

For drug allergens only

3.3 Which drug caused the reaction?
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For other eliciting factors only

3.4 Which other eliciting factor caused the reaction, please choose one: <input type="radio"/> Insect Venom, <i>please specify</i> <input type="text"/> <input type="radio"/> Latex, <i>please specify how (e.g., wearing latex gloves, etc)</i> <input type="text"/> <input type="radio"/> Specific immunotherapy (SIT), <i>please specify</i> <input type="text"/> <input type="radio"/> Exercise as the cause for anaphylaxis, in the absence of any other factor <input type="radio"/> Temperature e.g. heat/ cold-induced symptoms <input type="radio"/> Other eliciting factors not specified above: <input type="text"/>
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Section 4. Exacerbating factors and diseases

4.1 Does the patient have any concomitant diseases (including allergic diseases)? Yes No Unknown

If yes, which of the following concomitant diseases does the patient have and which occurred in the past?

Please circle one for each. Legend: Yes Ongoing (Y^{ongoing}), Yes in the past (Y^{past}), No (N), Unknown (UNK)

- Allergic rhinitis	Y ^{ongoing}	Y ^{past}	N	UNK	- Malignant diseases	Y ^{ongoing}	Y ^{past}	N	UNK
- Asthma/ COPD	Y ^{ongoing}	Y ^{past}	N	UNK	- Mastocytosis	Y ^{ongoing}	Y ^{past}	N	UNK
- Atopic dermatitis/eczema	Y ^{ongoing}	Y ^{past}	N	UNK	- (other) food allergies	Y ^{ongoing}	Y ^{past}	N	UNK
- Diabetes mellitus	Y ^{ongoing}	Y ^{past}	N	UNK	- Nasal polyps	Y ^{ongoing}	Y ^{past}	N	UNK
- Cardiovascular diseases	Y ^{ongoing}	Y ^{past}	N	UNK	- Thyroid disease	Y ^{ongoing}	Y ^{past}	N	UNK
- Chronic infection (e.g. HIV, HP-gastritis, TB, hep B/C)	Y ^{ongoing}	Y ^{past}	N	UNK	- Chronic urticaria	Y ^{ongoing}	Y ^{past}	N	UNK

Which cardiovascular disease are known/ has been diagnosed by the patient? Please choose one for each:

- | | | | |
|------------------------------|--|----------------------------|--|
| - Hypertension | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | - Congestive heart failure | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| - Coronary artery disease | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | - Arrhythmia: | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| - Prev myocardial infarction | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | - Other: | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |

Was the patient on antihistamines around the time of reaction? Yes No Unknown

4.2 Might the following conditions have contributed to reaction severity? Tick all that apply:

- | | |
|---|---|
| <input type="checkbox"/> An acute infection (e.g. common cold, flu) | <input type="checkbox"/> Hormone-based contraception / HRT |
| <input type="checkbox"/> Physical exercise as co-factor/ exacerbating factor, <i>please circle: mild/ moderate/ vigorous/ unknown</i> | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Psychological stress | <input type="checkbox"/> Sleep deprivation |
| <input type="checkbox"/> Drugs, <i>please specify</i> <input type="text"/> | <input type="checkbox"/> Other cofactors, <i>please describe</i> <input type="text"/> |
| <input type="checkbox"/> Menstruation | <input type="checkbox"/> None identified/ unknown |

Section 5. Treatment

Were emergency medical services contacted? 999 111/NHS direct No Unknown

5.1 Was any treatment given for initial management, and if so by whom? Please choose one:

- | | | |
|---|--|-------------------------------|
| <input type="radio"/> Non health professional | <input type="radio"/> First lay person followed by health professional | <input type="radio"/> Unknown |
| <input type="radio"/> Health professional | <input type="radio"/> No treatment | |

If given by a non health professional, which person?

Please choose one:

- Self-administered
- Family member
- Unknown

Drugs given by lay person or self-administered. Tick all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Patient's own adrenaline auto-injector | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Auto-injector belonging to someone else | <input type="checkbox"/> Corticosteroids |
| <input type="checkbox"/> Beta2-mimetics, e.g. Salbutamol | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Unknown |

If health professional, which person? Please choose one:

- Allergy specialist (Dr/nurse)
- General practitioner
- Pre-hospital
- In clinic / A&E department
- Other health professional

Drugs given by health professional. Tick all that apply and specify:

- | | |
|--|----------------------|
| <input type="checkbox"/> Adrenaline: <i>which route</i> | <input type="text"/> |
| <input type="checkbox"/> Antihistamines: <i>which route</i> | <input type="text"/> |
| <input type="checkbox"/> Beta2-mimetics: <i>which route</i> | <input type="text"/> |
| <input type="checkbox"/> Corticosteroids: <i>which route</i> | <input type="text"/> |
| <input type="checkbox"/> iv Fluids | |
| <input type="checkbox"/> Oxygen | |
| <input type="checkbox"/> Other: <i>circle</i> Dopamine, Glucagon, Methylene blue, Theophylline iv / oral | |
| <input type="checkbox"/> Unknown | |

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<p>5.3 Was a second dose of adrenaline administered? Please choose <u>one</u>:</p> <p><input type="radio"/> Yes, just one further dose</p> <p><input type="radio"/> Yes, more than two doses: <i>how many in total?</i> <input style="width: 50px;" type="text"/></p> <p><input type="radio"/> No</p> <p><input type="radio"/> Unknown</p>	<p>Who administered the second dose? Please choose <u>one</u>:</p> <p><input type="radio"/> Self/ lay (using auto-injector)</p> <p><input type="radio"/> Emergency paramedic</p> <p><input type="radio"/> Healthcare professional</p> <p><input type="radio"/> Unknown</p>
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5.5 Was further treatment needed following stabilisation of initial symptoms? Yes No Unknown

<p>If yes, who performed the SECOND LINE treatment?</p> <p><input type="radio"/> Allergy specialist (Dr/nurse)</p> <p><input type="radio"/> General practitioner</p> <p><input type="radio"/> Pre-hospital (Doctor/paramedic)</p> <p><input type="radio"/> In clinic/ ED</p> <p><input type="radio"/> Other health professional</p>	<p>Drugs given by health professional. Tick <u>all</u> that apply and specify:</p> <p><input type="checkbox"/> Adrenaline: <i>which route</i> <input style="width: 100px;" type="text"/></p> <p><input type="checkbox"/> Antihistamines: <i>which route</i> <input style="width: 100px;" type="text"/></p> <p><input type="checkbox"/> Beta2-mimetics: <i>which route</i> <input style="width: 100px;" type="text"/></p> <p><input type="checkbox"/> Corticosteroids: <i>which route</i> <input style="width: 100px;" type="text"/></p> <p><input type="checkbox"/> iv Fluids</p> <p><input type="checkbox"/> Oxygen</p> <p><input type="checkbox"/> Other: <i>circle</i> Dopamine, Glucagon, Methylene blue, Theophylline iv / oral</p>
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5.6.1 Was the patient admitted to the hospital because of the anaphylaxis reaction?

Yes No Unknown Not applicable

Where was the patient admitted to? Please choose one:

To hospital ward

To short-stay ward/ observation unit

Unknown

5.6.2 Was the patient treated in intensive care because of the anaphylactic reaction?

Yes No Unknown

Where was the patient treated? Please choose one:

Intensive care

High dependency unit or equivalent

Unknown

6 Discharge/ post-acute management

6.1 What advice/ follow-up management was provided following the episode? Known Unknown

If known, please tick all applicable boxes, at least one per row. *AAI=adrenaline autoinjector*

	Pt already <u>has</u>	Provided <u>pre-discharge</u>	GP requested <u>to provide</u>	Provided at <u>F/U clinic</u>	Not <u>given</u>
- Advice about potential triggers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Advice about avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Emergency Allergy Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Prescription for emergency medication*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- How to use AAI (with "trainer device")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- How to use AAI (no trainer device used)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Referral for allergen immunotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Referral to local allergy service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***6.2 If known, what kind of emergency drugs were prescribed following recovery from the reaction?**

	Pt already <u>has</u>	Provided <u>pre-discharge</u>	GP requested <u>to provide</u>	Provided at <u>F/U clinic</u>	Not <u>given</u>
- Adrenaline auto-injector (AAI)**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Adrenaline inhaler (not licensed in UK)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Reliever inhaler e.g. Salbutamol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Corticosteroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>**6.3.1 Which AAI device was prescribed?</p> <p><input type="radio"/> Emerade® <input type="radio"/> Epipen®</p> <p><input type="radio"/> Anapen® <input type="radio"/> Other</p> <p><input type="radio"/> Jext® <input type="radio"/> Unknown</p>	<p>How many AAI devices were prescribed?</p> <p><input type="radio"/> One</p> <p><input type="radio"/> Two</p> <p><input type="radio"/> More than 2 <input type="radio"/> Unknown</p>	<p>What dosage of AAI was prescribed?</p> <p><input type="radio"/> 150 mcg (0.15 mg)</p> <p><input type="radio"/> 300 mcg (0.3 mg)</p> <p><input type="radio"/> 500 mcg (0.5 mg)</p> <p><input type="radio"/> Unknown</p>
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