



# CAUTION

## ALLERGY / INTOLERANCE STATUS

### INITIAL ASSESSMENT

A Caution Sheet must be completed for each admission to PHC.  
A completed Caution sheet is required prior to dispensing or administering any medication or therapeutic agent by Pharmacy or Nursing.

Date: \_\_\_\_\_

**History Unobtainable**

An Allergy / Intolerance Assessment includes:  
History Unobtainable **or** Responses to all four areas.

DRUGS <input type="checkbox"/> None	Reaction	Contraindication
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>

### Maternity:

- Breastfeeding  
 Pregnant

### Source of Information:

- Patient / Resident  
 Old Chart / transfer form  
 Other: \_\_\_\_\_

FOOD* <input type="checkbox"/> None	Reaction

\* All food allergies MUST be entered into SCM using Diet Order (where SCM Order Entry available)

<b>LATEX</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> Contact
	<input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Anaphylaxis
<b>CONTRAST MEDIA</b>	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No <input type="checkbox"/> Unknown	
OTHER:		
OTHER:		

Faxed

Fax stamp  
Time & Date

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Discipline \_\_\_\_\_ College ID \_\_\_\_\_

### UPDATES

Complete update below, then write **"See Updated Caution Sheet"** on Prescriber's Orders.  
To discontinue an allergy or intolerance, draw a line through the entry, date and initial.

Date	Allergy / Intolerance	Reaction	Contraindication	Signature, Discipline & College ID	Date & Time FAXED
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		

**If further updates are required, use Caution Sheet Updates Form (PHC-PH397)**

Fax to Pharmacy, then place in red sheet protector at the front of the chart.  
This form takes precedence for this position over all other forms.

**DO NOT REMOVE FROM CHART**  
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