Etikett Patient:in

Information sublingual immunotherapy (SLIT)

The goal of sublingual immunotherapy (SLIT) is a reduction of the hypersensitivity to the substances that provoke allergic diseases. It is based on applying miniscule, precisely measured amounts of the substances to which one is allergic to the body, either in the form of drops or as tablets that dissolve under the tongue.

SLIT is carried out either **all year round** (e.g.: dust mites) or **pre-seasonally/co-seasonally** (pollen). The entire duration of the therapy is usually 3 years. After an initial daily dosage progression (depending on the preparation), a specific number of drops or an automatically dissolving tablet is applied under the tongue. The doctor will explain the respective dosage scheme to you. The first dose should be taken under medical supervision.

The following points are of the utmost importance

- Adhere to a fixed intake time (e.g. 5-10 min. before breakfast).
- Apply the drops/tablets under the tongue, keep in the mouth for at least two minutes and only then should you swallow.
- If you have an infection, inflammation of the oral mucosa or injuries in the mouth area, discontinue SLIT. Continuation of the treatment shall take place after consultation with the doctor.
- SLIT drops should be stored in as cool a place as possible. Once the bottle has been opened, it can also be stored at room temperature. Avoid freezing and temperatures over 40°C. Store the tablets in a dry place at room temperature.

Possible side effects

In the first 1-2 weeks in particular, local side effects are common. Contact the doctor if problems occur.

- Frequently: local symptoms such as itchiness in the oral cavity or throat
- Rarely: swelling of the mucosa, gastrointestinal complaints
- Extremely rarely: severe general allergic reactions, asthma

Declaration of consent

I have read and understood the information about my allergic disease and about the treatment options. My doctor has explained the planned immunotherapy to me and I hereby declare my agreement to the planned form of therapy and the selected preparation. My questions about this treatment have been answered. My doctor has explained the potential side effects that may occur to me and I am aware that successful healing cannot be predicted with complete certainty. If side effects occur, I will contact my attending doctor. I shall obtain further information from the patient information leaflet. In addition, the doctor continues to be available to me as a point of contact. I confirm that I have no further questions.

Vienna, ____.____.________
Date

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Signature of patient or legal guardian (if one parent is signing by themselves, they declare with their signature that they have sole custody or that they are acting in agreement with the other parent).

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Signature of doctor