



Devoted to Allergy Immunotherapy

# Skintestor OMNI™ Testing Sheet

Practice Name/Ordering Physician:			Telephone: (    ) -		
Street Address:			Fax: (    ) -		
City:	State:	Zip:	Email:		
Patient Name:			Patient ID:		

Date of Birth: ___/___/___	Last use of antihistamine (or other medication affecting response to histamine):				
	Days:	Medication:			

Location Back:                      Arm:                      Testing Technician:

PANEL A		Epicutaneous		Intradermal		PANEL C		Epicutaneous		Intradermal	
Site	Allergen or Extract	W (mm) F		W (mm) F		Site	Allergen or Extract	W (mm) F		W (mm) F	
1						1					
2						2					
3						3					
4						4					
5						5					
6						6					
7						7					
8						8					
9						9					
10						10					

PANEL B		Epicutaneous		Intradermal		PANEL D		Epicutaneous		Intradermal	
Site	Allergen or Extract	W (mm) F		W (mm) F		Site	Allergen or Extract	W (mm) F		W (mm) F	
1						1					
2						2					
3						3					
4						4					
5						5					
6						6					
7						7					
8						8					
9						9					
10						10					

Controls: Epicutaneous- NEGATIVE:		POSITIVE:		Intradermal - NEGATIVE:		POSITIVE:	
Epicutaneous-	Testing Date(s): ___/___/___			Testing Time:	<input type="checkbox"/> AM	<input type="checkbox"/> PM	
Intradermal-	Testing Date(s): ___/___/___			Testing Time:	<input type="checkbox"/> AM	<input type="checkbox"/> PM	