GREER allergy immunotherapy

GREER Pick® 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: Days: Medication:	Location: Back: ❑ Arm: ❑ Testing Technician:

Allergen	Epicutaneous W (mm)	Epicutaneous F	Intradermal W (mm)	Intradermal F
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
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24				
25				
26				
27				
28				
29				
30				

Allergen	Epicutaneous W (mm)	Epicutaneous F	Intradermal W (mm)	Intradermal F
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
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60				

Controls:	Epicutaneous:	NEGATIVE:	POSITIVE:	Intradermal:	NEGATIVE:	POSITIVE:
	Epicutaneous:	Testing Date(s): / /		Testing Time:	AM	PM
	Intradermal:	Testing Date(s): / /		Testing Time:	AM	PM

Practitioner Signature	Date

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