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		Intradermal		Allergen	Epicutaneous		Intradermal	
	W (mm)	F	W (mm)	F		W (mm)	F	W (mm)	F
1					31				
2					32				
3					33				
4					34				
5					35				
6					36				
7					37				
8					38				
9					39				
10					40				
11					41				
12					42				
13					43				
14					44				
15					45				
16					46				
17					47				
18					48				
19					49				
20					50				
21					51				
22					52				
23					53				
24					54				
25					55				
26					56				
27					57				
28					58				
29					59				
30					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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