GREER allergy immunotherapy

Skintestor OMNI™ MQT 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:

PANEL A		Epicutaneous	Intradermal		Endpoint	PANEL A		Epicutaneous	Intradermal		Endpoint
Site	Allergen	W (mm)	#2	#5		Site	Allergen	W (mm)	#2	#5	
1						6					
2						7					
3						8					
4						9					
5						10					

PANEL B		Epicutaneous	Intradermal		Endpoint	PANEL B		Epicutaneous	Intradermal		Endpoint
Site	Allergen	W (mm)	#2	#5		Site	Allergen	W (mm)	#2	#5	
1						6					
2						7					
3						8					
4						9					
5						10					

PANEL C		Epicutaneous	Intradermal		Endpoint	PANEL C		Epicutaneous	Intradermal		Endpoint
Site	Allergen	W (mm)	#2	#5		Site	Allergen	W (mm)	#2	#5	
1						6					
2						7					
3						8					
4						9					
5						10					

PANEL D		Epicutaneous	Intradermal		Endpoint	PANEL D		Epicutaneous	Intradermal		Endpoint
Site	Allergen	W (mm)	#2	#5		Site	Allergen	W (mm)	#2	#5	
1						6					
2						7					
3						8					
4						9					
5						10					

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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