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):<br>Days: Medication:<br>Days: Medication: | Location: Back: ❑<br>Arm: ❑<br>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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