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

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

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

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

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

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

PANEL F		Epicutaneous		Intradermal		PANEL F		Epicutaneous		Intradermal	
Site	Allergen	W (mm)	F	W (mm)	F	Site	Allergen	W (mm)	F	W (mm)	F
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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