STALLERGENES GREER

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:

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

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**