STALLERGENES GREER

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

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

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

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

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

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