SKIN TESTING DONE BY PRICK/SCRATCH/INTRADERMAL TECHNIQUE:
Please indicate significant positives and by what method:

1. Trees: _____
2. Grasses: _____
3. Weeds: _____
4. Molds: _____
5. Dust/Mite: _____
6. Animal Dander: _____
7. Other: _____

Immunotherapy (allergy shots) recommended Y/N

DATE STARTED: ESTIMATED DURATION:

Please review, with the patient, the potential risks of allergy shots (see our enclosed permit).

Date:_____Physician initials:_____

Please provide us with detailed prescription, contents, strengths (AU, PNU or wt/vol), and your recommendations for adjustment of dosages based on reactions. If you would like us to follow our standard protocol (see attached extract example prescriptions), please so indicate. Please return your printed instructions with the patient's extract.

Please initial here if you would like us to follow our shot dosage adjustment protocol:
Date:_____Physician initials:_____

If you have any additional instructions about your patient, please indicate below or attach additional sheet:

_____
Patient Signature:

_____
Typed/Printed Name:

_____
Address:

_____
Telephone:

_____
Physician Signature:

_____
Typed/Printed Name:

_____
Address:

_____
Daytime Phone: