Contact Dermatitis Clinic
Allergy Patch Test

Office Visit

Patient : Patient ID:

Allergies:
Medical History: Referring Provider:

Test Application Date: Test Type:

- ❑ Patch test Application X _____test(s)
- ❑ Consent Signed/Risk Reviewed
- ❑ Patient discharged in stable condition with written instruction/tape/contact numbers

_____

_____

_____

Reading 1 Date:

- ❑ Patches removed/ inked accordingly

_____

_____

_____

Additional Reading Date:

_____

_____

_____

_____

Completion of Case

Findings: _____

Relation: _____

Research: _____ Card/Counseling: _____

Dictated: _____ Consult: _____ Other: _____

Return Visit: Reviewed:
