Allergy Skin Test Documentation Guidelines

The allergy skin test form should provide enough information for other physicians and healthcare professionals to understand what tests were performed, how the tests were performed and to be able to interpret them. The AAAAI Immunotherapy, Allergen Standardization and Allergy Diagnostics Committee’s Guidelines for Reporting Immediate Skin Test Results recommends that the allergy skin test report form include the following information:

Patient information
   a) Patient name, date of birth and identifying number (if applicable)
   b) Ordering physician name, address and telephone number
   c) Testing date
   d) Last administration of medications that can interfere with skin test results or reactions (e.g., antihistamines, beta-blockers)

2) Allergy skin test methods
   a) Skin test technician
   b) Location of test (e.g. back, arm)
   c) Type of test (e.g., intradermal, prick, puncture)
   d) Instrument used (e.g., testing device, needle size, commercial kit)
   e) Time elapsed between application of tests and reading of tests
   f) Amount injected with intradermal technique

3) Testing Materials
   a) Positive and negative controls
   b) Manufacturing company or source of reagent
   c) Common name (scientific name optional)
   d) Concentration used in testing
   e) Dilution and diluent if applicable
   f) Contents, concentrations, diluents of any mixtures

4) Reporting of results
   a) Quantitative or semi-quantitative reporting based on wheal size, erythema/flare and pseudopodia.*
   b) Scoring reported as either measurement of wheal in millimeters, including presence or size of flare, or scoring as 0 through 4+ (key to scoring must be including, and must be based on measurement of wheal and flare)

*Note: The “Allergy diagnostic testing: an updated practice parameter” recommends that skin test results be reported as a measurement of the wheal and erythema-see below summary statements.

Summary Statement 9. The peak reactivity of prick/puncture tests is 15 to 20 minutes at which time both wheal and erythema diameters (or areas) should be recorded in millimeters and compared with positive and negative controls. (B)

Summary Statement 10. Qualitative scoring (0 to 4+; positive or negative) is no longer used by many clinicians because of inter-physician variability in this method of scoring and interpretation. (B)


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