

IN-VITRO ALLERGY ORDER/HISTORY FORM



including:
Spectrum Labs
Spectrum Health Care
Spectrum Worldwide

2143 E. 5th Street, Tempe, AZ 85281-3034 USA
(480) 464-8971 | (800) 553-1391 FAX: (480) 898-0611
www.vetallergy.com

Please complete this form as fully as possible, **including history portion**. Check appropriate boxes. Return form with sample in appropriate mailing container to **Alfamedic Ltd**, Tel + (852) 2982 2345.
3-5 ml of serum shipped at Room Temperature

Veterinarian _____
Clinic _____
Clinic Address _____
Phone (____) _____ Fax (____) _____

For Office Use Only:

Specimen No: _____ Date Rcvd: _____
Clinic Email _____
Receive results via email within 14 days of sample receipt
Animal's Name _____
Owner's Name _____
Breed _____
Age _____ Date _____

All testing will be carried out using the SPOT test, representing the ultimate in allergy testing



Canine SPOT Panels

Canine ULTIMATE SPOT PACKAGE
91 allergens panel



Feline SPOT Panels

Feline ULTIMATE SPOT PACKAGE
91 allergen panel

PRE-ORDER TREATMENT FOR ALL ALLERGENS (POSITIVE AND BORDERLINE)

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Patient History Information:

1. The signs include:

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Itchin | <input type="checkbox"/> Odor |
| <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Loss of Hair | |

Respiratory Problems

- Cough
 Sneeze
 Runny Nose

Gastrointestinal Problems

- Vomiting
 Diarrhea

Other _____

2. Has the animal ever been tested for allergies in the past?

- Yes No

If yes:

By Spectrum Labs Lab No. _____

Tested by other means. Specify _____

3. Has the animal ever been on allergy shot treatment?

- Yes No

When: _____

4. When are the symptoms the worst?

- Spring Summer Fall Winter Not Seasonal

5. At what age did you first notice the problem? _____

6. Has the animal been out of his/her normal area (vacation, boarding, etc.)?

- Yes No

Where: _____

When: _____

7. What type and brand of food do you feed your pet?

Canned: _____

Dry: _____

Table Scraps: _____

Other: _____

8. Does your pet use food supplements or vitamins?

- Yes No

Specify: _____

9. Do any members of your household smoke?

- Yes No

10. Is your pet exposed to any other animals?

- Yes No

Dog Cat Bird Other _____

11. What % of time is the pet indoors _____ outdoors _____?

12. Comments: _____

PLEASE FAX FORM TO ALFAMEDIC AT + (852) 2982 2775