

Allercept™ Allergen Panel Equine Order Form

Account #:	Owner name (Last):	(First):
Clinic name:	Patient name:	DOB:
Address:	Sex: Mare Gelding Stallion	
City, State, Zip:	Breed:	
Blood Collection Date:	Doctor:	

Equine Allercept Allergen Panel – 3.0 ml serum required

Lab Use Only: RT ST HT

Regional immunotherapy recommendation is based on clinic's location. If pet's primary location is different, provide pet's zip code(s):

PATIENT'S ALLERGY HISTORY

SECTION A – ENVIRONMENTAL EXPOSURES

Contact with other domestic animals:	Dog	Cat	Other:
Is tack shared:	Yes	No	
What is the horse fed:			
Access to pasture:	No	Yes, type:	

SECTION B – MEDICAL INFORMATION

Age of onset of clinical signs:	Does horse have COPD:			Yes	No			
Describe the major complaint:								
Select all that apply:	Crusts	Scales	Hives	Weight loss	Hair loss	Hair color change		
	Hair breakage	Coughing	Sneezing	Exercise intolerance	Nasal discharge	Ocular discharge		
Parasites (type):								
Is the disease:	Intermittent	Constant	Acute	Chronic				
Are clinical signs:	Non-Seasonal	Seasonal	During what months is the disease most severe:		Spring	Summer	Fall	Winter
Other diagnosed medical problems:								
What is your differential diagnosis:								

DIAGNOSTIC DATE PERFORMED RESULTS

Skin scrapings:
Surface cytology/biopsy:
Dermatophyte culture:
Fecal exam:
BAL:
Other:

TREATMENT DRUG NAME DATE EFFECTIVENESS

Corticosteroids:			Better	Worse	No change
Antihistamines:			Better	Worse	No change
Shampoo/rinse/spray:			Better	Worse	No change
Deworm:			Better	Worse	No change
Insecticide:			Better	Worse	No change
Other:			Better	Worse	No change

Questions? Email us at allergy.lvd@antechdx.com.