# Diagnostic Services Request

For care available at our Anchorage office

## Referring Doctor

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<tr>
<th>Name</th>
<th>Address</th>
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<tr>
<th>Phone (___)</th>
<th>Date of Referral</th>
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## Patient Information

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<tr>
<th>Phone: Hm (___)</th>
<th>Wk (___)</th>
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## Assessment

Working Diagnosis ____________________________________________________________________________

ICD-10 Code (required) ________________________________________________________________________

## Services Requested

### OD OS OU

- [ ] Topography/Pentacam
- [ ] Pachymetry
- [ ] Visual field

Test strategy requested

Can patient be safely dilated with tropicamide and phenylephrine?

- [ ] Yes
- [ ] No, please explain. ______________________________________________________________________

Optical Coherence Tomography (OCT):

- [ ] Angle analysis
- [ ] Corneal analysis
- [ ] Macular analysis
- [ ] Optic nerve head analysis
- [ ] Retinal nerve fiber layer

If visual field or OCT is requested, please provide refraction.

OD ____________ 20/____
OS ____________ 20/____

Unless requested, these tests will be provided without interpretation.

Do you want us to interpret test results for you?

- [ ] Yes

## Areas of Interest

If OCT or photos are requested, please indicate and/or comment on the areas of interest.

__________________________________________________________________________________________

__________________________________________________________________________________________

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Revised 2017-7   Fax to (907) 272-2428 or mail to PCLI 1600 A St, Suite 200 Anchorage, AK 99501