

Diagnostic Services Request

For care available at our Anchorage office



REFERRING DOCTOR

Name _____

Address _____

Phone (____) _____

Date of Referral _____

PATIENT INFORMATION

Name _____

Address _____

Phone: Hm (____) _____ Wk (____) _____

Date of Birth _____

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

If not, 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/ _____

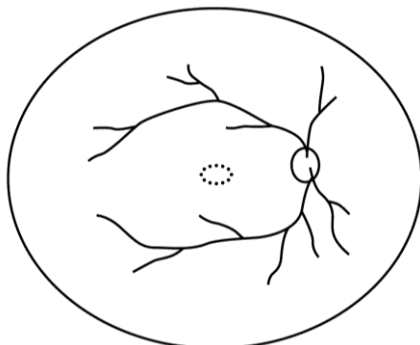
Unless requested, these tests will be provided without interpretation.

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. _____

OD



OS

