Diagnostic Services Request

For care available at our Bellevue office

CATARACT AND LASER INSTITUTE

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
☐ Anterior segment photos	☐	☐	☐
☐ Topography/Pentacam	☐	☐	☐
☐ Disc photos	☐	☐	☐
☐ Fundus photos	☐	☐	☐
☐ Pachymetry	☐	☐	☐
☐ Visual field	☐	☐	☐

Test strategy requested _____

Optical Coherence Tomography (OCT):

☐ Angle analysis	☐	☐	☐
☐ Corneal analysis	☐	☐	☐
☐ Macular analysis	☐	☐	☐
☐ Optic nerve head analysis	☐	☐	☐
☐ Retinal nerve fiber layer (GCC)	☐	☐	☐

Unless requested, these tests will be provided without interpretation.
Do you want us to interpret test results for you? ☐ Yes

Can patient be safely dilated with tropicamide and phenylephrine?

☐ Yes

If not, please explain. _____

_____

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

OD _____ 20/ _____

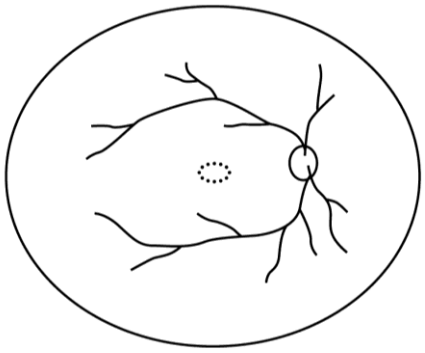
OS _____ 20/ _____

AREAS OF INTEREST

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

_____

OD



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