Diagnostic Services Request

For care available at our Boise 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
☐ Anterior segment photos	☐	☐	☐
☐ Topography/Pentacam	☐	☐	☐
☐ Disc photos	☐	☐	☐
☐ Fundus photos	☐	☐	☐
☐ Pachymetry	☐	☐	☐
☐ Visual field	☐	☐	☐

Test strategy requested ____________________

Optical Coherence Tomography (OCT):

	OD	OS	OU
☐ Angle analysis	☐	☐	☐
☐ Corneal analysis	☐	☐	☐
☐ Macular analysis	☐	☐	☐
☐ Optic nerve head analysis	☐	☐	☐
☐ Retinal nerve fiber layer	☐	☐	☐

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/ _______

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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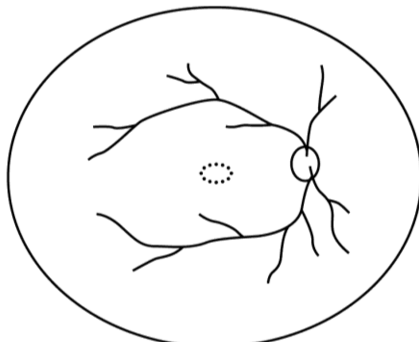
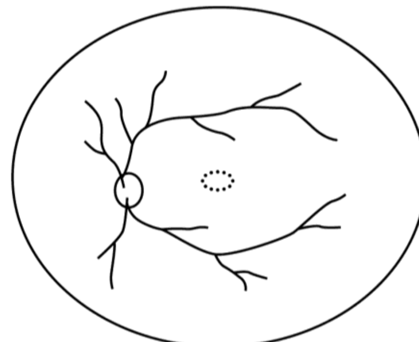
OD



OS



Revised 2017-7 Fax to (208) 385-0050 or mail to PCLI 2822 S Vista Ave, Boise, ID 83705