

Diagnostic Services Request

For care available at our Chehalis 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 |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Anterior segment photos | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Corneal topography | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Disc photos | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Fundus photos | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> HRT optic nerve analysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pachymetry | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Specular microscopy endothelial study | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Visual field | | | |

Test strategy requested _____

Optical Coherence Tomography (OCT):

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Angle analysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Corneal analysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Macular analysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Optic nerve head analysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Retinal nerve fiber layer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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. _____

Can patient be safely dilated with tropicamide and phenylephrine?

Yes

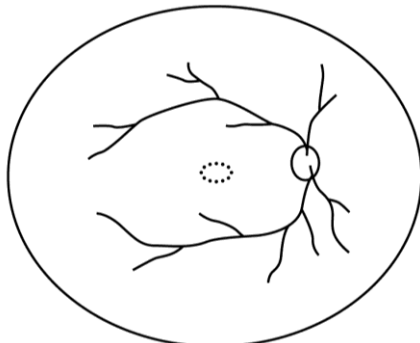
If not, please explain. _____

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

OD _____ 20/ _____

OS _____ 20/ _____

OD



OS

