Diagnostic Services Request

For care available at our Kennewick 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	☐	☐	☐
☐ Corneal topography	☐	☐	☐
☐ Disc photos	☐	☐	☐
☐ Fundus photos	☐	☐	☐
☐ HRT optic nerve analysis	☐	☐	☐
☐ Pachymetry	☐	☐	☐
☐ Specular microscopy endothelial study	☐	☐	☐
☐ Visual field	☐	☐	☐
Test strategy requested _______________________			
Optical Coherence Tomography (OCT):			
☐ 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.

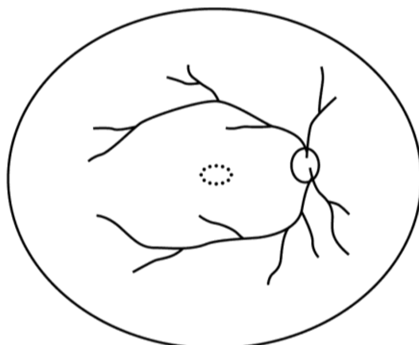
Do you want us to interpret test results for you? ☐ Yes

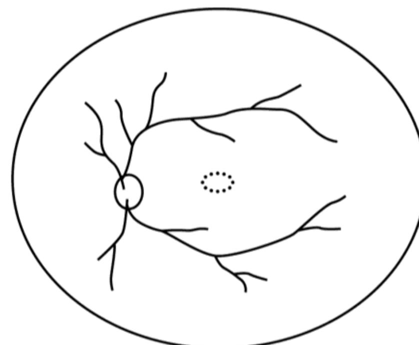
AREAS OF INTEREST

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

____

OD **OS**





Fax to (509) 735-6868 or mail to PCLI 6695 W Rio Grande Avenue, Kennewick, WA 99336