

# 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

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Anterior segment photos               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Topography/Pentacam                   | <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"/> 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                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 (GCC) | <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

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.

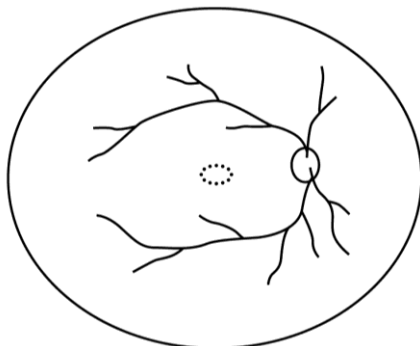
OD \_\_\_\_\_ 20/ \_\_\_\_\_

OS \_\_\_\_\_ 20/ \_\_\_\_\_

## AREAS OF INTEREST

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

OD



OS

