Diagnostic Services Request

For care available at our Portland, Tualatin and Vancouver offices

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

Where our office location is shown in brackets the service is only available at that facility.

Service	OD	OS	OU
☐ Anterior segment photos (Portland)	☐	☐	☐
☐ Posterior segment photos (Portland)	☐	☐	☐
☐ Corneal topography	☐	☐	☐
☐ Pachymetry	☐	☐	☐
☐ Pentacam (Portland and Tualatin)	☐	☐	☐
☐ Visual field	☐	☐	☐

Test strategy requested ____________

Optical Coherence Tomography (OCT):

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

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 visual field or OCT is requested, please provide refraction.

OD ____________ 20/ _______

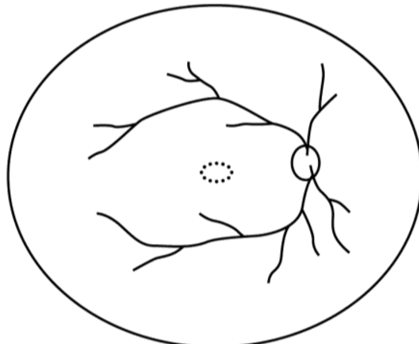
OS ____________ 20/ _______

AREAS OF INTEREST

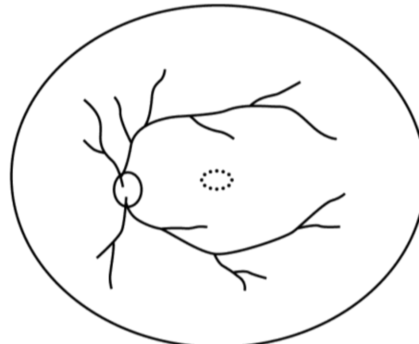
If OCT or photos are requested, please indicate and/or comment on the areas of interest. ____________

____

OD



OS



000 (Rev. 11/16) Mail or fax to PCLI Portland, Tualatin or Vancouver