Diagnostic Services Request

For care available at our Silverdale 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
☐ B-scan ultrasonography	☐	☐	☐
☐ Topography/Pentacam	☐	☐	☐
☐ 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	☐	☐	☐

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. ____

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____

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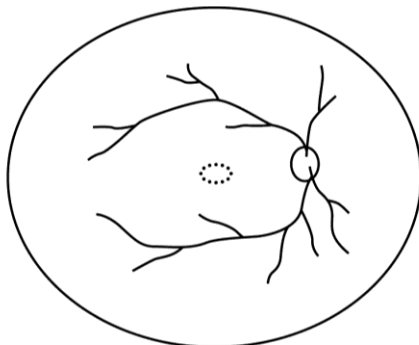
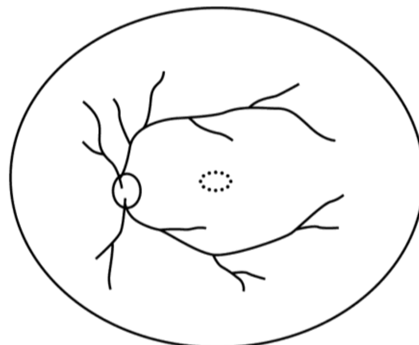
OD



OS



 Fax to (360) 698-5231 or mail to PCLI 9598 Mickelberry Road NW, Silverdale, WA 98383