# Diagnostic Services Request

For care available at our Spokane office

Pacific CATARACT AND LASER INSTITUTE

**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 | ☐ | ☐ | ☐ |
| ☐ Topography/Pentacam | ☐ | ☐ | ☐ |
| ☐ Disc photos | ☐ | ☐ | ☐ |
| ☐ Fundus photos | ☐ | ☐ | ☐ |
| ☐ 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 | ☐ | ☐ | ☐ |

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/ _____

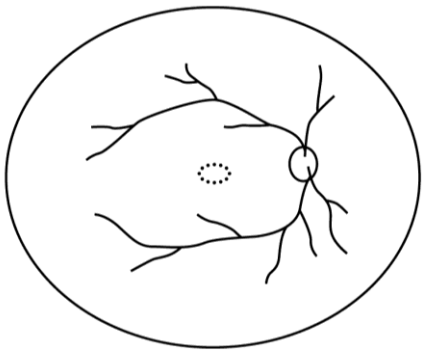
OS _____ 20/ _____

**AREAS OF INTEREST**

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

_____

**OD**



**OS**