

# Diagnostic Services Request

For care available at our Tacoma 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"/> Corneal topography       | <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"/> HRT optic nerve analysis | <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"/> Pentacam                 | <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 | <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

## AREAS OF INTEREST

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

Can patient be safely dilated with tropicamide and phenylephrine?

Yes

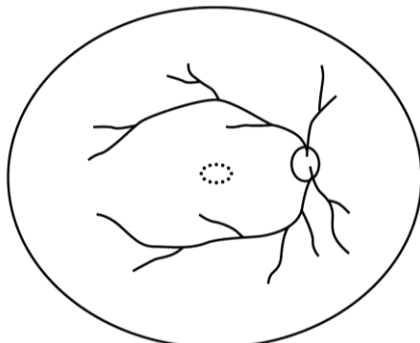
If not, please explain. \_\_\_\_\_

If fundus photos, visual field, or OCT is requested, please provide refraction.

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

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

OD



OS

