



PHYSICIAN ORDER FOR DIAGNOSTIC SERVICE

Name _____ Phone # _____ Age _____ M / F Date _____

Requesting Physician(s) _____ Phone Results ASAP Send Results by Mail

Corrected Visual Acuity: OD 20/_____ OS 20/_____ Allergies : _____

1. GDx: OU OD OS Dr. Initials _____ Tech. Initials _____ Date to be done: _____

Suspected Diagnosis: _____

Results : _____ Findings and Implications : _____

Impact on Plan : _____ Physician Signature : _____ Date : _____

2. Visual Field: OU OD OS Dr. Initials _____ Tech. Initials _____ Date to be done: _____

24-2 Sita Standard 10-2 (plaquenil) Suspected Diagnosis: _____

30-2 Sita Standard Kinetic (ptosis) Other: _____

Current Rx.: OD _____ ADD _____ OS _____ ADD _____

Results : _____ Findings and Implications : _____

Impact on Plan : _____ Physician Signature : _____ Date : _____

3. Optic Nerve Photo Review: Dr. Initials _____ Tech. Initials _____ Date to be done: _____

Results : _____ OD _____ OS Suspected Diagnosis : _____

Findings and Implications : _____ Physician Signature : _____ Date : _____

4. Gonioscopy: OU OD OS Dr. Initials _____ Tech. Initials _____ Date to be done: _____

Suspected Diagnosis: _____

Results : _____ Findings and Implications : _____

Impact on Plan : _____ Physician Signature : _____ Date : _____

5. Serial Tenometry: OU OD OS Dr. Initials _____ Tech. Initials _____ Date to be done: _____

Suspected Diagnosis : _____

Results : _____ OD _____ OS Findings and Implications : _____

Impact on Plan : _____ Physician Signature : _____ Date : _____

6. Potential Acuity Testing: (PAM) Dr. Initials _____ Tech. Initials _____ Date to be done: _____

OU OD OS Suspected Diagnosis: _____

Results : _____ Findings and Implications : _____

Impact on Plan : _____ Physician Signature : _____ Date : _____

7. Corneal Topography: OU OD OS Dr. Initials _____ Tech. Initials _____ Date to be done: _____

Normalized Absolute Suspected Diagnosis: _____ R/O K-conus

Results : _____ Findings and Implications : _____

Impact on Plan : _____ Physician Signature : _____ Date : _____

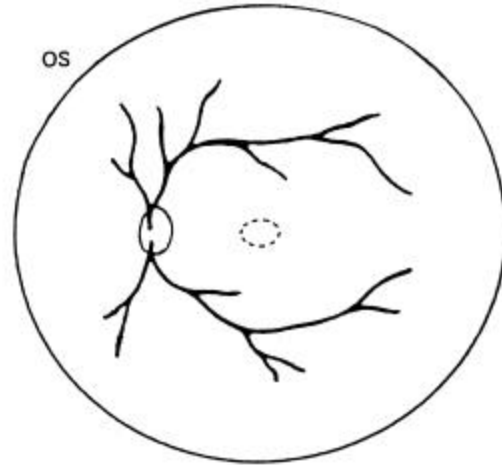
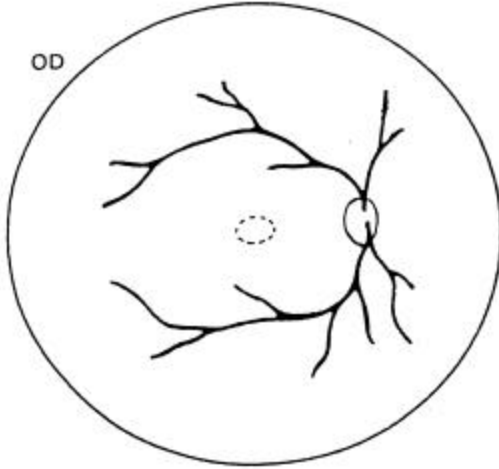
8. B-SCAN: OU OD OS Dr. Initials _____ Tech. Initials _____ Date to be done: _____

Results : _____ Findings and Implications : _____

Impact on Plan : _____ Physician Signature : _____ Date : _____

9. Fundus Photography: OU OD OS Dr. Initials _____ Tech. Initials _____ Date to be done: _____
 DISC 7 STD. Special Area (Please Specify) Suspected Diagnosis : _____
 Results : _____ Findings and Implications : _____
 Impact on Plan : _____ Physician Signature : _____ Date : _____

10. Fluorescein Angiography: OD OS Dr. Initials _____ Tech. Initials _____ Date to be done: _____
 (w/Fundus Photo) Start Angio* (transit) OD OS Suspected Diagnosis: _____
 Results : _____ Findings and Implications : _____
 Impact on Plan : _____ Physician Signature : _____ Date : _____



Circle: Exact Area for early phase angiography

* Early phase angiography can be done in one eye only

11. External Photography: Anterior Segment (please specify) _____ Blepharochalasis Series
 OU OD OS Dr. Initials _____ Tech. Initials _____ Date to be done: _____
 Suspected Diagnosis: _____
 Results : _____ Findings and Implications : _____
 Impact on Plan : _____ Physician Signature : _____ Date : _____

TECHNICIAN : _____ INJECTOR : _____ TIME : _____ DATE : _____

COMMENTS : _____

PATIENT QUESTIONS : _____

DATE : PATIENT / REQUESTING / REFERRING DR. CONTACTED : _____ INITIALS : _____

COMMENTS : _____