719

**Cincinnati Eye Institute**

**DIAGNOSTIC TESTING ORDER AND INTERPRETATION**

Acct# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Send Test Results to:

Fax To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mail To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***Must complete form in entirety for test to be performed**

Referring Dr’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD 10 Code/ DX Statement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scheduled Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpretation by CEI Doctor ❒ Yes ❒ No

|  |  |
| --- | --- |
| ANTERIOR SEGMENT DEPARTMENT |  |
| ❒ Wave-Scan (will require patient payment in advance) | ❒ OD ❒ OS ❒ OU |
| ❒ A-Scan / IOL Master (requires cataract or pseudophakic diagnosis) | ❒ OD ❒ OS ❒ OU |
| ❒ UBM (Requires a consultation with a CEI doctor) | ❒ OD ❒ OS ❒ OU |
| ❒ Pentacam/Topography (use room/Ant Seg/Test/BA/Level 1) | ❒ OD ❒ OS ❒ OU |
| \*Refraction data required: MR OD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | For axial testing, submit manual K data: |
|  MR OS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   |
| RETINA / PHOTO DEPARTMENT |  |
| **\*All patients will be dilated. Please advise patient to bring driver.** |  |
| ❒ Fundus Photos ❒ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❒ OD ❒ OS ❒ OU |
| ❒ Fluorescein Angiogram \_\_\_\_\_\_\_\_\_\_ eye first if OU | ❒ OD ❒ OS ❒ OU |
| ❒ ICG \_\_\_\_\_\_\_\_\_\_ eye first if OU | ❒ OD ❒ OS ❒ OU |
| OCT ❒ Retina Map ❒ Glaucoma Map | ❒ OD ❒ OS ❒ OU |
| ❒ Infrared | ❒ OD ❒ OS ❒ OU |
| ❒ Autofluorescence  | ❒ OD ❒ OS ❒ OU |
| ❒ Full Field ERG ❒ Multifocal ERG ❒ EOG | ❒ OD ❒ OS ❒ OU |

INTERPRETATION: ❒ Full Retinal Consult / Clinical Correlation Required

**Order form must be faxed to 513-984-4240.**

**Please send hard copy with patient.**

CEI CLN-10