Ivey Eye Institute
Ophthalmic Diagnostic Services
St. Joseph's Hospital
268 Grosvenor Street, Room B1-409
London, Ontario N6A 4V2
TEL: 519 646-6018 FAX: 519 646-6248

GENERAL/CORNEA/GLAUCOMA DIAGNOSTIC REQUISITION

PATIENT NAME ______________________
SURNAME GIVEN INITIAL

ADDRESS ______________________

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TELEPHONE: (____) ______________________

HEALTH CARD# ______________________
10 DIGITS VERSION CODE

DATE OF BIRTH: ______________________ **AGE** ☐

APPOINTMENT DATE: ______________________ **TIME:** __________

REFERRING OPHTHALMOLOGIST: ______________________ **COPIES TO:** __________

PATIENT HAVING MULTIPLE TESTS: ☐ YES ☐ NO ______________________

Seeing MD same day ☐ YES ☐ NO

If mydriasis is required for any of the procedures, phenyltrope (or tropicamide 1.0% phenylphrine 2.5%) will be instilled for this purpose.

Physician: ______________________ ______________________
SIGNATURE PRINT NAME

ALLERGIES: ☐ NKA ☐ Yes Specify: ______________________

DISTANCE SPECTACLE CORRECTION:

Right Eye ______________________

Left Eye ______________________

Distance Visual Acuity

Right Eye ______________________

Left Eye ______________________

POTENTIAL ACUITY METER (PAM)

Please indicate which eye(s) to be tested

☐ Right Eye ______________________

☐ Left Eye ______________________

DISC PHOTOS Right Eye ☐ Left Eye ☐ Both Eyes ☐

VISUAL FIELD TESTING

Please indicate which eye(s) to be tested: Right Eye ☐ Left Eye ☐ Both Eyes ☐

Humphrey sita standard

☐ 10-2

☐ Red Stimulus ☐ White Stimulus ☐ 120 Point Full Field

☐ 24-2 ☐ Other __________

☐ 30-2 Comments:

☐ Goldmann

Heidelberg Retina Tomograph ☐

Right Eye ☐ Left Eye ☐

Glaucoma Imaging Package ☐

HRT & DISC PHOTOS ☐ Right Eye ☐ Left Eye

Clinical Diagnosis ______________________

IOL Master Right Eye ☐ Left Eye ☐ Both Eyes ☐

	Right Eye	Left Eye
Immersion Axial Length	☐	☐
Keratometry	☐	☐

	Right Eye	**Left Eye**
Orbscan (Corneal Topography)	☐	☐
Optical Pachymetry/Specular Microscopy	☐	☐
Ultrasound Pachymetry	☐	☐

Previous Eye Surgery

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Diagnosis

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Date: (YYY/MM/DD) __________ Technician: ______________________ ______________________
PRINT NAME SIGNATURE