ST JOSEPH'S HEALTH CARE LONDON

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

RETINA REQUISITION

PATIENT NAME _____ (SURNAME / GIVEN / INITIAL)

ADDRESS _____

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: _____

CURRENT MEDICATIONS: _____

CLINICAL DIAGNOSIS (MANDATORY): _____

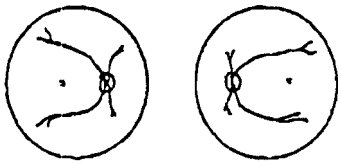
DISTANCE VISUAL ACUITY: Right Eye _____ Left Eye _____

OPHTHALMIC PHOTOGRAPHY (please illustrate area(s) to be photographed)

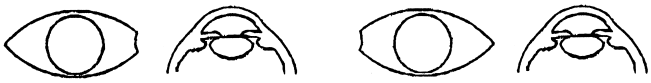
	Right Eye	Left Eye	Both Eyes
Fundus Photo	☐	☐	
Disc Photo	☐	☐	☐
Retinal Fluorescein Angiography			
Early Phase	☐	☐	☐
Late Phase	☐	☐	
Anterior Segment			
Lids	☐	☐	
Cornea	☐	☐	
Conj/Sciera	☐	☐	
Iris	☐	☐	
Lens	☐	☐	
Goniography	☐	☐	
Other	☐	☐	
External			
Full Face	☐	☐	☐
Ocular Motility	☐	☐	

B-Scan/Fundus
(Illustrate Retinal Pathology - ie: nevus)

Right Eye ☐ Left Eye ☐

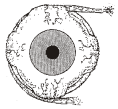


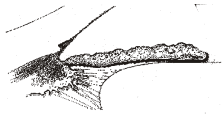
☐ Lesion - Photo required with ultrasound



Right Eye ☐ Left Eye ☐

UBM - Ultrasound Biomicroscopy
Reason for Examination
(Please illustrate using diagrams)





Optical Coherence Tomography (O.C.T.)
Test Options (please check)

1. Macular Cube ☐
2. 5 Line Raster ☐
3. Optic Disc Cube ☐

Pathology _____

Electrophysiology

	Right Eye	Left Eye
VER	☐	☐
ERG	☐	☐
EOG	☐	☐

Colour Vision

	Right Eye	Left Eye
100 HUE	☐	☐
D-15	☐	☐

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

White Copy-Medical Records Yellow Copy-Diagnostic Services

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