### 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: 519 646-6052

---

### GENERAL/CORNEA/GLAUCOMA DIAGNOSTIC REQUISITION

<table>
<thead>
<tr>
<th>APPOINTMENT DATE:</th>
<th>TIME:</th>
</tr>
</thead>
</table>

**REFERRING OPHTHALMOLOGIST:**

**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:**

---

**ALLERGIES:**

- [ ] NKA
- [ ] Yes

Specify: __________________________________________

**DISTANCE SPECTACLE CORRECTION:**

**Distance Visual Acuity**

<table>
<thead>
<tr>
<th>Right Eye</th>
<th>Left Eye</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**VISUAL FIELD TESTING**

**Please indicate which eye(s) to be tested:**

- [ ] Humphrey sita standard
  - [ ] 10-2
  - [ ] Red Stimulus
  - [ ] White Stimulus
  - [ ] 24-2
  - [ ] 30-2
  - [ ] Goldmann

- [ ] 120 Point Full Field
- [ ] Other

Comments: _______________________________________

**DISC PHOTOS**

- [ ] Right Eye
- [ ] Left Eye
- [ ] Both Eyes

---

**Clinical Diagnosis**

---

**Previous Eye Surgery**

---

**Diagnosis**

---

---

Date: (YY/MM/DD) ____________________________  Technician: ______________________

---

White Copy = Medical Records  Yellow Copy = Diagnostic Services

Rev. 10/2017  64115