

**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 \_\_\_\_\_

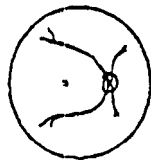
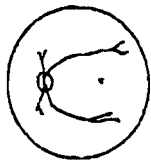


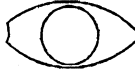

**ALLERGIES:**  NKA  Yes Specify: \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_

**CLINICAL DIAGNOSIS (MANDATORY):** \_\_\_\_\_

**DISTANCE VISUAL ACUITY:** OD \_\_\_\_\_ OS \_\_\_\_\_

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

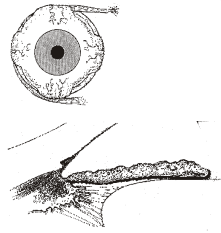
	OD	OS	OU		B-Scan/Fundus (Illustrate Retinal Pathology - ie: nevus)	OD	OS
Fundus Photo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Disc Photo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Retinal Fluorescein Angiography</b>							
Early Phase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Late Phase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Anterior Segment</b>							
Lids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Cornea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Conj/Sciera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Iris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Lens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Goniography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>External</b>							
Full Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Ocular Motility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Lesion - Photo required with ultrasound

**UBM - Ultrasound Biomicroscopy**

OD  OS

**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**

	OD	OS
VER	<input type="checkbox"/>	<input type="checkbox"/>
ERG	<input type="checkbox"/>	<input type="checkbox"/>
EOG	<input type="checkbox"/>	<input type="checkbox"/>

**Colour Vision**

	OD	OS
100 HUE	<input type="checkbox"/>	<input type="checkbox"/>
D-15	<input type="checkbox"/>	<input type="checkbox"/>

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