



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 _____

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: **Distance Visual Acuity**

OD _____ OD _____
 OS _____ OS _____

POTENTIAL ACUITY METER (PAM)
 Please indicate which eye(s) to be tested

OD _____
 OS _____

VISUAL FIELD TESTING

Please indicate which eye(s) to be tested: OD OS OU

Humphrey sita standard 10-2
 Red Stimulus White Stimulus 120 Point Full Field
 24-2 Other _____
 30-2
 Goldmann

Comments: _____

DISC PHOTOS OD OS OU

Heidelberg Retina Tomograph
 OD OS

Glaucoma Imaging Package
 HRT & DISC PHOTOS OD OS

Clinical Diagnosis _____

| | | | | |
|---|------------------------------------|------------------------------------|-----------------------------|--|
| IOL Master | OD <input type="checkbox"/> | OS <input type="checkbox"/> | OU <input type="checkbox"/> | Previous Eye Surgery _____ _____ _____ |
| Immersion Axial Length | OD <input type="checkbox"/> | OS <input type="checkbox"/> | | |
| Keratometry | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Orbscan (Corneal Topography) | OD <input type="checkbox"/> | OS <input type="checkbox"/> | | Diagnosis _____ _____ _____ |
| Optical Pachymetry/Specular Microscopy | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Ultrasound Pachymetry | <input type="checkbox"/> | <input type="checkbox"/> | | |

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