



OPHTHALMIC IMAGING CENTER REFERRAL

Please FAX completed form to: 916-734-6992

- Imaging only*
- Imaging with Interpretation*

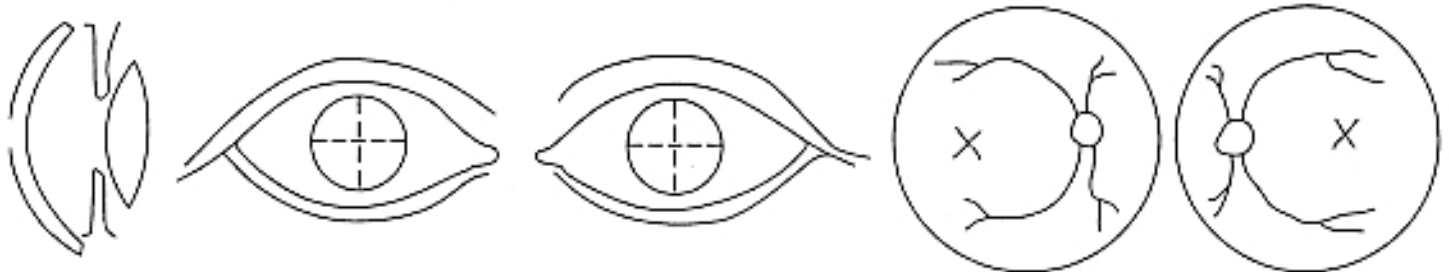
REFERRING PHYSICIAN: _____ / _____
print last name signature telephone

PATIENT NAME: _____ SEX: _____ DOB: _____ REQUEST DATE: _____

CLINICAL HISTORY:

DIAGNOSIS: _____ VA: OD: _____ OS: _____

Please draw area(s) to be imaged:



Please indicate type(s) of imaging needed: (Note: All procedures are done in digital format unless otherwise indicated.)

<u>FUNDUS:</u>	OD	OS	OU
<input type="checkbox"/> Color Fundus Photos	_____	_____	_____
<input type="checkbox"/> Stereo Color Fundus (3DX)	_____	_____	_____
<input type="checkbox"/> Red Free	_____	_____	_____
<input type="checkbox"/> HRT	_____	_____	_____
<input type="checkbox"/> OCT (indicate scan pattern)	_____	_____	_____
<input type="checkbox"/> Macula <input type="checkbox"/> Optic nerve			
<input type="checkbox"/> Other _____			

<u>ULTRASOUND</u>	OD	OS	OU
<input type="checkbox"/> A-Scan	_____	_____	_____
<input type="checkbox"/> B-Scan	_____	_____	_____
<input type="checkbox"/> 3-D			
<input type="checkbox"/> Anterior Segment (UBM)	_____	_____	_____

<u>ANTERIOR SEGMENT:</u>	OD	OS	OU
<input type="checkbox"/> Slit-Lamp Photos	_____	_____	_____
<input type="checkbox"/> Specular Microscopy	_____	_____	_____
<input type="checkbox"/> External			
<input type="checkbox"/> Full Face <input type="checkbox"/> 2-eye <input type="checkbox"/> Strabismus			
<input type="checkbox"/> Corneal Topography			
<input type="checkbox"/> Orb Scan <input type="checkbox"/> OPD (wavefront) Scan			

ANGIOGRAPHY: (Color Fundus Imaging Included)

<input type="checkbox"/> Fluorescein	Sequence:
<input type="checkbox"/> ICG	Transit Phase:
<input type="checkbox"/> Iris	<input type="checkbox"/> OD <input type="checkbox"/> OS
	Mid & Late:
	<input type="checkbox"/> OU <input type="checkbox"/> OD <input type="checkbox"/> OS