TESTING REQUEST

SightLine Ophthalmic Associates
Phone 724-933-5588 • Fax 724-933-6051

PATIENT NAME _____

DATE OF BIRTH _____

REFERRING DOCTOR _____

DATE OF EXAM _____

□ I have scheduled an appointment for this patient on:

_____

□ I would like Sightline to call this patient to schedule:

PATIENT PHONE _____

SERVICES REQUESTED:

- □ GDX
- □ VISUAL FIELD (□ 24-2 □ 10-2)
- □ PACHYMETRY
- □ ENDOTHELIAL CELL COUNT
- □ ANTERIOR SEGMENT PHOTOS
- □ TOPOGRAPHY
- □ OCT-CORNEA
- □ OCT-OPTIC NERVE
- □ OCT-RETINA/MACULA
- □ OTHER: _____

WOULD YOU LIKE US TO EXAMINE THIS PATIENT? □ YES □ NO, just send the printouts with interpretation.

REFRACTION (only required for GDX & visual field): R _____ 20/_____

L _____ 20/_____

ASSESSMENT (please complete one of the following):

- DIAGNOSIS/ICD-10 CODE:_____
- SUSPECTED DIAGNOSIS: _____
- UNKNOWN DIAGNOSIS (SIGNS OR SYMPTOMS CAUSING NEED FOR TESTING):

_____

_____

_____

_____ Report Faxed to SightLine

Signature _____