

**COMPUTERIZED OPTIC DISC IMAGING AND
NERVE FIBER LAYER ANALYSIS TEST REQUEST FORM**

Please complete the following information

GDx **HRT** **OCT**

1. Patient's Name _____ D.O.B. _____

2. UPHS MRN _____ (if known)

3. Patient Insurance Plan _____ Group # _____

Referral Needed? _____ If yes, please attach Referral # _____

4. Requesting Physician _____

5. Requesting Physician Address

Phone _____

Fax _____

5. Diagnosis _____

6. Dilation orders

Neosynephrine 10% _____ Right Eye _____

Cyclogyl _____ Left Eye _____

Mydracyl _____ Both Eyes _____

No Drops _____

7. Refraction

| EYE | SPHERE | CYLINDER | AXIS | VISUAL ACUITY |
|-----|--------|----------|------|---------------|
| OD | | | | |
| OS | | | | |

8. Eye to be tested O.D. _____ O.S. _____ O.U. _____

Call (215) 662-8100 to schedule

Fax form to Scheie Medical Records (215) 662-8110

For questions, call (215) 662-8055, for OCT call Photography Lab at (215) 662-8127

Scheduled Date _____ **Time** _____

Scheduled by _____