

VISUAL FIELD TEST REQUEST FORM

Please complete the following information

Goldmann **Humphrey** **FDT** **Octopus**

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. _____

9. Check Options for Type of Test Ordered

Humphrey:

30-2 SITA-Standard _____ 30-2 SITA-Fast _____ Stimulus size ____ III ____ V

24-2 SITA-Standard _____ 24-2 SITA-Fast _____ Stimulus size ____ III ____ V

10-2 SITA-Standard _____ 10-2 SITA-Fast _____ Stimulus size ____ III ____ V

10-2 red _____

SWAP (blue-yellow perimetry) _____

Octopus:

Full threshold ____ 30 degree, ____ 10 degree Stimulus size ____ III ____ V

TOP (fast strategy) ____ 30 degree ____ 10 degree Stimulus size ____ III ____ V

Kinetic (Goldmann strategy) _____

FDT:

Screening test _____

Full-threshold test _____

Call (215) 662-8100 to schedule. Fax form to Scheie Medical Records (215) 662-8110

For questions, call the Visual Fields Service at (215) 662-8055

Scheduled Date _____ Time _____

Scheduled by _____