ST JOSEPH's HEALTH CARE LONDON

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: 519 646-6052

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:

Right Eye ______________________________

Left Eye ______________________________

Distance Visual Acuity

Right Eye ______________________________

Left Eye ______________________________

POTENTIAL ACUITY METER (PAM)

Please indicate which eye(s) to be tested

☐ Right Eye ______________________________

☐ Left Eye ______________________________

VISUAL FIELD TESTING

Right Eye	Left Eye	Both Eyes
☐	☐	☐

Please indicate which eye(s) to be tested:

Humphrey sita standard

☐ 10-2

☐ Red Stimulus ☐ White Stimulus

☐ 24-2

☐ 30-2

☐ Goldmann

☐ 120 Point Full Field

☐ Other ______________

Comments:

DISC PHOTOS

Right Eye	Left Eye	Both Eyes
☐	☐	☐

Clinical Diagnosis ______________________________

Right Eye	Left Eye	Both Eyes
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

Previous Eye Surgery

____

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____

Diagnosis

____

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

White Copy = Medical Records Yellow Copy = Diagnostic Services

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