# DIAGNOSTIC REQUISITION FORM

iCare Surgical & Optical Centre

**2148 Carling Ave**
**Suite 205**
**Ottawa, ON K2A 1H1**
**Phone: 613-596-0300**
**Fax: 613-596-0848**
**icarecentre.org**

| | |
|---|---|
| Patient: | |
| OHIP: | |
| Phone: | |
| Address: | |
| Date: | |

| HAS THE PATIENT BEEN TO iCARE PREVIOUSLY? | ☐ Yes | ☐ No |
|---|---|---|

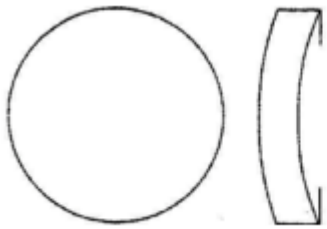
| MANDATORY CODIFICATION | ☐ Semi Urgent (1-3 weeks) | ☐ Priority (1-4 months) | ☐ Elective (4+ months) |
|---|---|---|---|

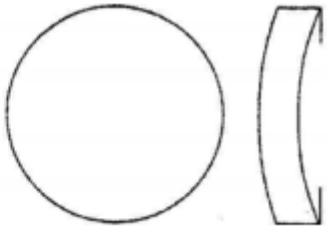
| DIAGNOSIS | |
|---|---|
| ALLERGIES | |

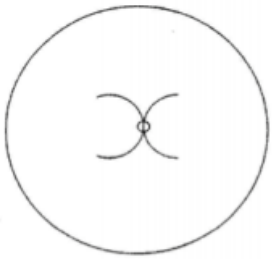
| VISUAL ACUITY | | Sph | Cyl | Ax | VA |
|---|---|---|---|---|---|
| | OD | | | | |
| | OS | | | | |

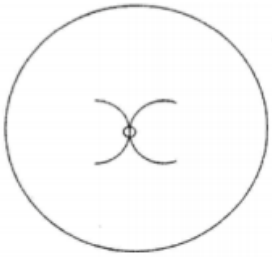
**Please indicate on diagram where to pay close attention:**

| OD | OS | OD | OS |
|---|---|---|---|
| Slit Lamp | | Fundus | |









Ophthalmologist / Optometrist: _____
Billing #: _____

| REQUESTED DIAGNOSTIC TESTS PLEASE CIRCLE | | | |
|---|---|---|---|
| Angiography | VF 24-2 | Biometry | Corneal Topography |
| RET OCT | VF 10-2 | Pachymetry | Anterior Segment OCT |
| GL OCT | VF 30-2 | Wide Field Fundus Photography | B-Ultrasound |
| Autofluorescence | VF Estermann | A-Scan | Other: _____ |

| NOTES / COMMENTS |
|---|
| |