

DIAGNOSTIC REQUISITION FORM



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icarecentre.org

Patient:
OHIP:
Phone:
Address:
Date:

HAS THE PATIENT BEEN TO ICARE PREVIOUSLY? Yes No

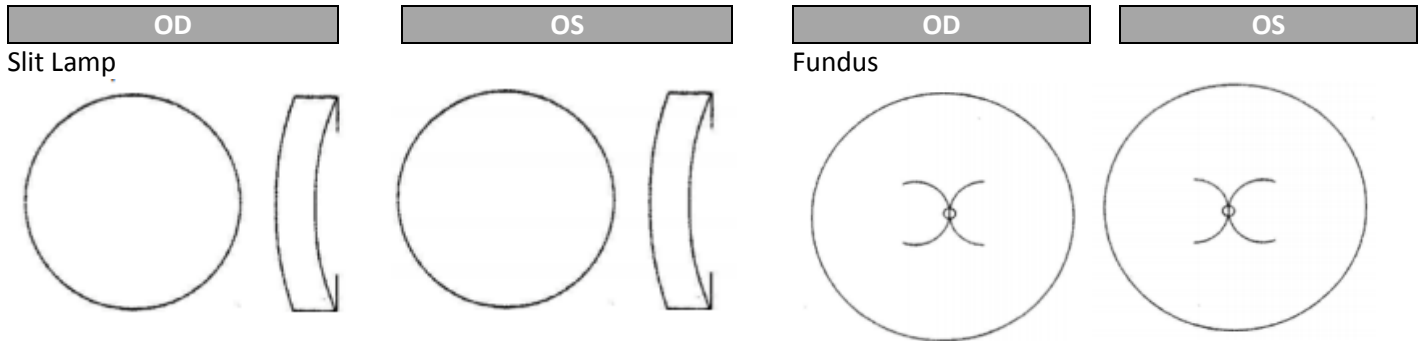
MANDATORY CODIFICATION Semi Urgent (1-3 weeks) Priority (1-4 months) Elective (4+ months)

DIAGNOSIS

ALLERGIES

VISUAL ACUITY		Sph	Cyl	Ax	VA
	OD				
	OS				

Please indicate on diagram where to pay close attention:



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
