Reset this Form

THE NEW YORK EYE AND EAR INFIRMARY
RETINA DIAGNOSTIC CENTER- NORTH BUILDING, 8TH FLOOR
ORDER FORM

*** Web Form**

Patient Name _____ **Date of Birth** _____ **Date/Time of Order** _____

Diagnosis _____ **Diagnosis Code** _____ **Authorization # (if needed)** _____

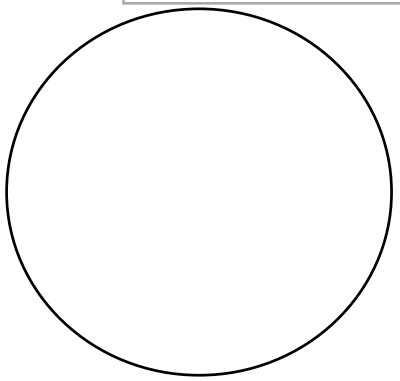
Ordering Physician Name (Printed) _____ **Physician Signature** _____

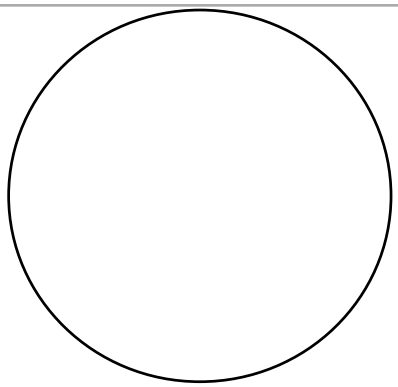
Eye (circle)			Procedure
OD	OS	OU	A-Scan ☐
OD	OS	OU	B-Scan 2D 3D ☐
OD	OS	OU	UBM ☐
OD	OS	OU	ERG/mERG/EOG ☐
OD	OS	OU	VEP (do not dilate) ☐
OD	OS	OU	F/A ☐
OD	OS	OU	ICG ☐
OD	OS	OU	F/A on HRA ☐
OD	OS	OU	ICG on HRA ☐
OD	OS	OU	HRT ☐
OD	OS	OU	Disc Photos/Fundus Photos ☐
OD	OS	OU	Auto Fluorescence ☐
OD	OS	OU	OCT Macula Disc ☐
OD	OS	OU	SLO-OCT ☐
OD	OS	OU	Microperimetry ☐
OD	OS	OU	Slit Lamp Photos ☐

Special Testing Needs _____

Other Instructions _____

OD





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