SISKIYOU EYE CENTER

DIAGNOSTIC INSTRUMENT REFERRAL FORM

Fax completed form to: Ashland 541-488-5081 Yreka 530-842-5839

REFERRING DOCTOR: _____

Address:_____
(Please indicate the address you would like all information sent)

Doctor Phone Number: _____

Patient Last Name _____ First Name _____ DOB _____

Patient Rx: OD _____ 20/_____ OS_____ 20/_____

Diagnosis:_____

Appointment Date:_____

(Please have the patient bring all billing/insurance information to their appointment)

☐ Arrange consultation at time of testing

Indicate Desired Studies:	**Doctor interprets?**
☐ Automated Humphrey Visual Field	yes / no
☐ Corneal Topograpy	yes / no
☐ Fundus Photography, disc	yes / no
☐ Fundus Photography, macular	yes / no
☐ Goldmann Visual Field	yes / no
☐ OCT, macular	yes / no
☐ OCT, optic nerve, RNFL	yes / no
☐ HRT	yes / no
☐ FDT	yes / no
☐ Stereo Photography	yes / no