UNIVERSITY EYE CENTER
FERRIS STATE UNIVERSITY

MEDICAL AND SURGICAL SERVICE

Philip E. Walling, OD David J. Barrett, MD

Referral Form for Testing

Referring provider:_____

Patient name:_____ **DOB:**_____

Reason for Referral:_____

Diagnosis/ICD-9:_____ **Interpretation of results:** ❑ **Your office** ❑ **MCO**

Testing requested: (please indicate below)

- ❑ **Visual field:** OD, OS, OU
  - ❑ 24-2: OD, OS, OU
  - ❑ 10-2: OD, OS, OU
  - ❑ Superior 36: OD, OS, OU

- ❑ **Fundus photography**
  - ❑ Macula: OD, OS, OU
  - ❑ ONH: OD, OS, OU
  - ❑ Posterior pole: OD, OS, OU

- ❑ **Cirrus Spectral Domain Ocular Coherence Tomography (SD-OCT)**
  - ❑ Macula: OD, OS, OU
    - ❑ High definition 5-line raster
    - ❑ Macular cube 512 x 128
  - ❑ ONH: OD, OS, OU
    - ❑ Optic disc cube 200 x 200
    - ❑ Optic disc cube 200 x 200 with RNFL analysis

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