UNIVERSITY EYE CENTER
FERRIS STATE UNIVERSITY

# MEDICAL AND SURGICAL SERVICE

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## Referral Form for Testing

**Referring provider:**________________________________________________

**Patient name:**______________________________________**DOB:**__________**Interpretation of results: ❑ Your office ❑ MCO**

| **Glaucoma** (please indicate diagnosis) | **Plaquenil** (please indicate diagnosis) |
|---|---|
| ❑ Preglaucoma, unspecified: bilateral - H40.003<br>❑ Open angle with borderline findings, low risk: bilateral - H40.013<br>❑ Open angle with borderline findings, high risk: bilateral - H40.023 | ❑ Other long term (current) drug therapy - Z79.899 |
| **Other:**________________________________________ | |

### Testing requested: (please indicate below)

❑ **Humphrey visual field**
- 24-2: ❑ OD, ❑ OS, ❑ OU
- 10-2: ❑ OD, ❑ OS, ❑ OU
- Superior 36: ❑ OD, ❑ OS, ❑ OU
- Matrix N-30-5 screening field: ❑ 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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