

RETINA NORTHWEST, P.C.

DIAGNOSTIC SCHEDULING WORKSHEET

Date: _____

Time: _____

Location:

- ___ Lake Oswego
- ___ Lovejoy
- ___ Providence
- ___ St. Vincent
- ___ Vancouver

Please remember to tell your patients that they should expect to be with us for at least 1 to 2 hours, and we suggest they bring a driver due to longer lasting dilation.

Referring Physician Dr. _____ MD
 _____ OD Phone: () _____
 _____ DO

Schedule Within: _____ Next Available _____ Days _____ Weeks _____ Months Spoke With: _____

Patient Name _____ DOB _____

Address _____

HOME WORK CELL Phone () _____ HOME WORK CELL Phone: () _____

Contact (if other than patient) _____

Comments: _____

Primary Insurance: _____ Secondary Insurance: _____

ID: _____ ID: _____

Group: _____ Group: _____

Subscriber: _____ Subscriber: _____

Diagnosis: _____

Study being requested:

___ Cirrus OCT (Spectral Domain) (SD) ALL LOCATIONS OS OD OU

___ Spectralis OCT (Spectral Domain) (SD) Lovejoy only OS OD OU

___ Color Fundus Photos ALL LOCATIONS

___ OPTOS Wide Field Lovejoy Only OS OD OU

___ Fluorescein Angiogram ALL LOCATIONS

Is FA Interpretation Required? ___ Yes ___ No OS OD OU

___ Ultrasound

___ Standardized A-Scan Lovejoy Only OS OD OU

___ Standardized B-Scan All Locations

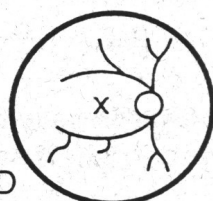
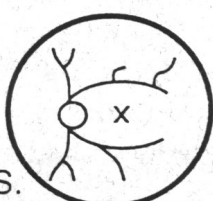
Signed Physician Orders are required for all studies being requested

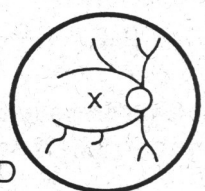
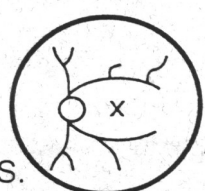
Please fax completed form and orders to: 866-843-7990 or call 503-274-2121 if *URGENT* or if you have questions.

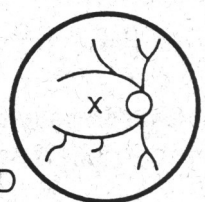
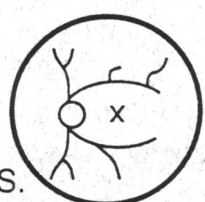
Retina Northwest Ophthalmic Outside Diagnostic Orders

Patient Name: _____ Date of Birth: _____	Ordering Physician: _____ DX/ICD10 CODE: _____
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OCT	<input type="checkbox"/> OS <input type="checkbox"/> OD <input type="checkbox"/> OU	<input type="checkbox"/> OCT: OPTIC NERVE <input type="checkbox"/> Guided Progressive Analysis Report <small>(only available if pt. has had 3 or more studies of the same eye, at the same location)</small> <input type="checkbox"/> OCT: MACULA All OCT's require interpretation. Physician Signature: _____
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COLOR PHOTOS	<input type="checkbox"/> OS <input type="checkbox"/> OD <input type="checkbox"/> OU <input type="checkbox"/> D + M <input type="checkbox"/> 7 Field	<input type="checkbox"/> COLOR FUNDUS PHOTOGRAPHY <input type="checkbox"/> 2X DISC (Zeiss only) <input type="checkbox"/> OPTOS WIDE FIELD <u>Lovejoy Only</u> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <p style="text-align: right;">Circle exact areas to be photographed</p> <p>Notes: _____</p> Interpretation: <input type="checkbox"/> Yes <input type="checkbox"/> No (Interpretation not available on Disc Photos for Glaucoma) Physician Signature: _____
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ANGIOGRAPH	<input type="checkbox"/> OS <input type="checkbox"/> OD <input type="checkbox"/> OU <input type="checkbox"/> D + M <input type="checkbox"/> 7 Field	<input type="checkbox"/> FUNDUS FLUORESCIN ANGIOGRAPHY (includes Color Photos) <u>All Locations</u> <input type="checkbox"/> OPTOS Wide Field <u>Lovejoy Only</u> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <div style="margin-left: 200px;"> <input type="checkbox"/> Circle exact area of <u>primary interest</u> in early phase. <input type="checkbox"/> Put a square around areas to be photographed in mid and late phases. </div> <p>Notes: _____</p> Interpretation: <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Signature: _____
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ULTRASOUND	<input type="checkbox"/> OS <input type="checkbox"/> OD <input type="checkbox"/> OU	<input type="checkbox"/> Standardized A-Scan <u>Lovejoy Only</u> <input type="checkbox"/> Standardized B <u>All Locations</u> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <div style="margin-left: 200px;"> <input type="checkbox"/> Circle area of interest for lesions </div> <p>Notes: _____</p> Physician Signature: _____
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I would like results: On DVD Printed Both

RNW Use: Pt. Dilated: _____ Results Mailed: _____ Orders scanned into DHC: _____