LOYOLA UNIVERSITY CHICAGO STRITCH SCHOOL OF MEDICINE

DEPARTMENT OF

OPHTHALMOLOGY

The Loyola University Medical Center

Diagnostic Testing Service (DTS) Referral Form

Patient Name: _____ DOB: _____

Diagnostic Test Requested:

Anterior segment OCT:	Cornea	Iris/Angle	
Humphrey Visual Field:	24-2	30-2	10-2
Posterior segment OCT:	Optic Nerve	Macula/Retina	
Fluorescein Angiogram:	Transit	OD	OS
Fundus Photography:	Stereo Disc	Macula	Other: _____
Other Tests:	Topography	Tomography	Specular Microscopy
	Slit Lamp Photography	A-scan Ultrasound/ IOL Master	

Brief Clinical History:

_____

Best Corrected Visual Acuity: OD: 20/ OS: 20/

Presumed Diagnosis:

For Fundus Photos and Fluorescein Angiogram indicate area of interest:

☐ **Check for testing only without interpretation** (not recommended for fluorescein angiogram or macular OCT)

Referring Physician Name: **Phone:** **Fax:**

Office Address:

To schedule a DTS appointment, please call (708) 216-2750 and fax this form to (708) 216-2778