

Time: _____
(request in box)

University of Rochester Eye Institute
Fundus Photography and Angiography Request Form

601 Elmwood Ave – Box #659
Rochester, NY 14642

For Appointments call: (585) 275-3446
FAX forms to: (585) 506-4185

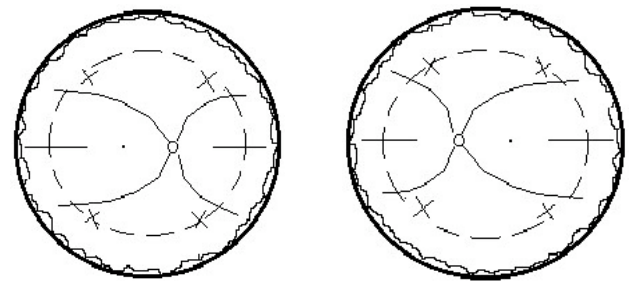
DO NOT COVER DR'S NAME WITH LABEL

Patient Name: _____
DOB: _____
Referring Doctor: _____
Place of referral: _____

Diagnosis: _____
Date of Test: _____
 Scheduled or Unscheduled/same day
For Angiograms: Pt ID: ID Band Verbal Other:

- Color Fundus Photography
- RetCam – Pediatric Contact Fundus Photography
- OCT* (booked thru retinal services at 273-3982 with Drs Chung/Diloreto)

Field	Stand 3 fields (1, 2 & post pole)	Disc Photos (1x/2x)	Fields 1, 2, 3	Sweep - 8 Fields	OCT
<input type="radio"/> OU					<input type="radio"/> OU
<input type="radio"/> OD					<input type="radio"/> OD
<input type="radio"/> OS					<input type="radio"/> OS



OD

OS

- 20°
- 30°
- 50°

Comments/Special Instructions: _____
Time Dilated: _____

Fluorescein Angiogram (FA) / Indocyanine Green (ICG): (Important: check **all** areas below)

Test(s) to be done: FA only ICG only both FA and ICG

Primary Eye (transit eye): OD **or** OS

Specific Location: macula center disc center other, specify: _____

Lates: OU angiogram only on primary eye

Fundus photos: yes (chart above) no, not necessary

Please note: The patient and referring physician **must** both sign a consent form for a FA and/or ICG. Patients who have an allergy to iodine or shellfish should not have an ICG done. Patients who are on Glucophage or Metformin-containing drugs will not have an ICG done unless it is discontinued 72 hours prior to the angiogram and not resumed until 72 hours after the angiogram.

Previous FA? ___ N ___ Y: any problems? ___ N ___ Y, List: _____
Previous ICG? ___ N ___ Y: any problems? ___ N ___ Y, List: _____
 Meds Checked Allergies checked (including Latex, Iodine) List: _____ Is patient pregnant: N Y
Pre BP: _____ Pre Pulse: _____ Demonstrates good understanding: Yes No, requires reinforcement
Post BP: _____ Post Pulse: _____ Injection done: _____ by: _____

Date done: _____ Eyes: OU OD OS
Time _____
Finished: Castillo Fischer Howell Schaefer
 other: _____
 No charge Test, Reason: _____

(code: 516)	OD	OS	OU
FP	<input type="checkbox"/> 0425	<input type="checkbox"/> 0425	<input type="checkbox"/> 0426
FA	<input type="checkbox"/> 0410	<input type="checkbox"/> 0410	<input type="checkbox"/> 0411
ICG	<input type="checkbox"/> 0414	<input type="checkbox"/> 0414	<input type="checkbox"/> 0415
OCT	<input type="checkbox"/> 0412	<input type="checkbox"/> 0412	<input type="checkbox"/> 0413

- AION 377.41
- Angioid Streaks 363.43
- ARMD 362.50
- ARMD, Dry 362.51
- ARMD, Wet 362.52
- BDR 362.01
- Best's Disease 362.76
- BRAO 362.32
- BVO 362.36
- Choroidal Hemorrh. 363.61
- CME 362.53
- CNV 362.16
- Coates (362.12)
- CRAO 362.31
- CRVO 362.35
- CSR 362.41
- Diabetic Retinopathy 362.01
- Drusen, ON 377.21
- Drusen, Retina 362.57
- Epiretinal Membrane 362.56
- Glaucoma 365.90
- Glaucoma Sus 365.00
- Histoplasmosis 115.92
- Hypertensive Retin. 362.11
- Macular edema 362.83
- Macular hole/cyst 362.54
- Macular Pucker 362.56
- Macular Scar/lesion 363.32
- Myopic Degen. 360.21
- Nevus ret/Chor. 224.60
- Ocular Hyperten. 365.04
- O. N. atrophy 377.10
- Optic Neuritis 377.30
- Papilledema 377.00
- PDR 362.02
- POAG 365.11
- Pseudoexfol. Gl. 365.52
- Pseudotumor C. 348.20
- Retinal Detach. 361.90
- Retinal Hem. 362.81
- Retinal Scar/Les. 363.30
- Retinitis Pigmentosa 362.74
- Retinopathy 362.10
- Rod-Cone Dystrophy 362.10
- ROP 362.21
- RPE Atrophy 362.76
- RPE Defect 362.76
- RPE Hem. 362.43
- Vitreous Hem. 379.23
- VKH 364.24

Pt location: Cornea waiting rm Retina/Neuro waiting rm Neuro dilating Retina Dilating Clinic waiting rm Exam room #:
When test done: Pt to see ref doctor Pt can check-out Other: _____