



Ivey Eye Institute
Ophthalmic Diagnostic Services
St. Joseph's Hospital
268 Grosvenor Street, Room B1-409
London, Ontario N6A 4V2

TEL: 519 646-6018 FAX: 519 646-6052

RETINA REQUISITION

PATIENT NAME	SURNAME	GIVEN	INITIAL
ADDRESS			
TELEPHONE: ()			
HEALTH CARD#	10 DIGITS	VERSION CODE	
DATE OF BIRTH:			AGE

APPOINTMENT DATE: _____ TIME: _____

REFERRING OPHTHALMOLOGIST: _____ COPIES TO: _____

PATIENT HAVING MULTIPLE TESTS: ☐ YES ☐ NO _____

Seeing MD same day ☐ YES ☐ NO

If mydriasis is required for any of the procedures, phenyltrope (or tropicamide 1.0% phenylphrine 2.5%) will be instilled for this purpose.

Physician: _____

SIGNATURE _____ PRINT NAME _____

ALLERGIES: ☐ NKA ☐ Yes Specify: _____

CURRENT MEDICATIONS: _____

CLINICAL DIAGNOSIS (MANDATORY): _____

DISTANCE VISUAL ACUITY: Right Eye _____ Left Eye _____

OPHTHALMIC PHOTOGRAPHY (please illustrate area(s) to be photographed)

	Right Eye	Left Eye	Both Eyes
Fundus Photo	☐	☐	
Disc Photo	☐	☐	☐

Retinal Fluorescein Angiography

Early Phase	☐	☐	☐
Late Phase	☐	☐	

Anterior Segment

Lids	☐	☐
Cornea	☐	☐
Conj/Sciera	☐	☐
Iris	☐	☐
Lens	☐	☐
Goniography	☐	☐
Other	☐	☐

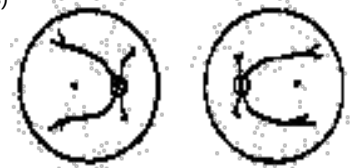
External

Full Face	☐	☐	☐
Ocular Motility	☐	☐	

B-Scan/Fundus

(Illustrate Retinal Pathology - ie: nevus)

Right Eye	Left Eye
☐	☐



- ☐ Lesion - Photo required with ultrasound
- ☐ Optic Disc Drusen - Photo required with ultrasound

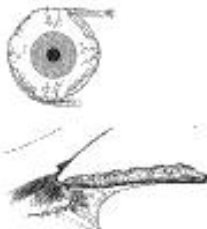


Right Eye	Left Eye
☐	☐

UBM - Ultrasound Biomicroscopy

Reason for Examination

(Please illustrate using diagrams)



Optical Coherence Tomography (O.C.T.)

Test Options (please check)

- | | |
|--------------------------|--------------------------|
| 1. Macular Cube | ☐ |
| 2. 5 Line Raster | ☐ |
| 3. Optic Disc Cube | ☐ |
| 4. Spectralis and/or FAF | ☐ |

Pathology _____

Electrophysiology

	Right Eye	Left Eye
MFERG	☐	☐
VER	☐	☐
ERG	☐	☐
EOG	☐	☐

Colour Vision

	Right Eye	Left Eye
100 HUE	☐	☐
D-15	☐	☐

Date: (YYY/MM/DD) _____ Technician: _____

PRINT NAME _____ SIGNATURE _____