Alberta Health Services

Eye Clinic Diagnostic Service Requisition

Once a request is scheduled, the patient and your office will be notified. Any diagnostic that requires interpretation will need additional time for reporting.

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown		
Patient Phone Number		

Referred to *(choose one)*

☐ Eye Institute of Alberta **(Edmonton)**
Royal Alexandra Hospital, Main Level, ATC 1111
10240 Kingsway Avenue, Edmonton AB T5H 3V9
Phone 780.735.5754 **Fax** 780.735.5830
www.ahs.ca/eia

☐ Eye Clinic **(Calgary)**
Rockyview General Hospital, 4th floor (Main level)
7007 - 14th Street SW, Calgary AB T2V 1P9
Phone 403.943.3720 **Fax** 403.943.3392

Can Patient Be Safely Dilated? *(check if applicable to diagnostic test)* ☐ Yes ☐ No

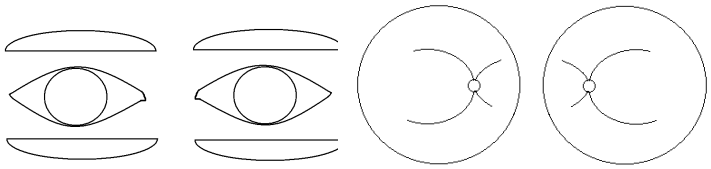
Patient Mobility Status
☐ Walking ☐ Transferrable ☐ Non-transferrable

Diagnosis/History/Indication *(What question do you want answered?)*

Visual Acuity Right _____ Left _____

Refraction Right _____
Left _____

Indicate Area of Interest
(Applicable to FA, ICG, Photos, OCT & Ultrasounds)



Angiography - ***Patient Care Orders required***
☐ Fluorescein Angiography
☐ ICG Angiography *(Contraindications: Shellfish/Iodine Allergies)*
Primary Eye ☐ Right ☐ Left
Image Other Eye ☐ Yes ☐ No

Photos
☐ Fundus ☐ Disc
☐ Autofluorescence (FAF) ☐ Lesion
☐ Slit lamp ☐ Gonio
External ☐ 0,45,90 ☐ 9-Gaze
☐ Other *(specify)* _____

Ultrasounds & IOL Calculations
☐ B Scan ► ☐ Both ☐ OD ☐ OS
☐ UBM ► ☐ Both ☐ OD ☐ OS
☐ Optical Biometry *((IOLM/Argos)(Ascan will be performed if unobtainable/ unreliable)*
☐ Ascan ☐ Muscle Measurements _____
Interpreting Physician ***(Calgary Only)*** _____

Other
☐ Corneal Topography ☐ Specular Microscopy *(Endo)*
☐ Pachymetry ☐ PAM
☐ Manual Keratometry ☐ Other _____

OCT-Posterior Segment
☐ Macula ☐ OCT-A ***(Calgary Only)***
☐ Optic Nerve ☐ EDI
☐ Lesion
☐ BaF-Blue-Peak Auto-fluorescence ***(Edmonton Only)***
☐ Other _____

Orthoptics
☐ Orthoptics Assessment (Attach last clinic sheet)
OR
☐ Fresnel Fitting Only *(Fee for Fresnel)*
☐ Hess Chart Only ☐ Synoptophore Only

OCT-Anterior Segment
☐ Cornea ☐ Sclera ☐ Angles ☐ Other _____
☐ HRT ***(Edmonton Only)***

Color Vision ☐ Ishihara ☐ FM100 Hue ☐ D-15

IOP Reading
☐ Single ☐ Serial ☐ ORA ***(Calgary Only)***

Visual Fields
Static Visual Fields *(ie Humphrey Visual Fields)*
☐ 30-2 ☐ 24-2 ☐ 24-2C ☐ 10-2 ☐ red target
☐ 30-2-sita-fast ☐ 24-2-sita-fast ☐ 24-2-sita-faster
☐ Binocular Estermann ☐ Other _____
Kinetic Visual Fields *(ie Octopus:Cgy/Edm, Goldmann:Cgy Only)*
☐ Octopus/Goldmann Right & Left separately
☐ Octopus/Goldmann Binocular

Electrodiagnostic Testing
☐ Multifocal (mfERG)
☐ Full Field (ffERG)
☐ VEP
☐ EOG
☐ Dark Adaptation
☐ Full Field Sensitivity Threshold (FST) (Edm only)

Comments

Ordering Physician	Signature	Fax	Date *(dd-Mon-yyyy)*