4860 Y Street, Suite 2400
Sacramento, California 95817-2307
(916) 734-6602 office
(916) 734-6992 facsimile
www.ucdmc.edu/eyecenter

OPHTHALMIC IMAGING CENTER REFERRAL

REQUEST DATE: _____

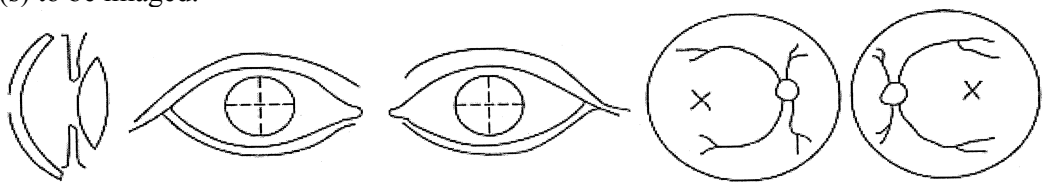
REFERRING PHYSICIAN: _____/_____ _____
Print last name signature telephone

PATIENT NAME: _____ SEX: _____ DOB: _____

CLINICAL HISTORY:

DIAGNOSIS: _____ VA: OD: _____ OS: _____

Please draw area(s) to be imaged:



Indicate type(s) of imaging needed: *(Note: All procedures are done in digital format unless otherwise indicated)*

FUNDUS:	OD	OS	OU
☐ Color Fundus Photos	___	___	___
☐ Stereo Color Fundus (3DX)	___	___	___
☐ Red Free	___	___	___
☐ HRT	___	___	___
☐ OCT (indicate scan pattern)	___	___	___
☐ Macula ☐ Optic Nerve			
☐ Anterior Segment			
☐ Enhanced Depth Imaging (EDI)			
☐ Auto Fluorescence			

ANTERIOR SEGMENT:	OD	OS	OU
☐ Slit-Lamp Photos	___	___	___
☐ Specular Microscopy	___	___	___
☐ Corneal Topography	___	___	___
☐ Confocal Microscopy	___	___	___
☐ External			
☐ Full Face ☐ 2-eye ☐ Strabismus			

ULTRASOUND:

Please use Ultrasound request form

ANGIOGRAPHY: *(Color Fundus Imaging Included)*

☐ Fluorescein
☐ ICG
☐ Iris

Sequence:
Transit Phase:
☐ OD ☐ OS
Mid & Late:
☐ OU ☐ OD ☐ OS