UCDAVIS
EYE CENTER

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

OPHTHALMOLOGY
ULTRASOUND REQUEST FORM

PATIENT NAME: _____ SEX: ____ DOB: _____ REQUEST DATE: _____

REQUESTING M.D. (please ***print & sign*** name): _____ / _____ P.I.#: _____
Print last name Signature

After imaging, the patient may: ☐ leave ☐ return to clinic

EVALUATE:	**OD**	**OS**	**OU**
☐ A-Scan	____	____	____
☐ B-Scan	____	____	____
☐ Movie Format	____	____	____
☐ Biometry (with report)	____	____	____
☐ UBM Anterior Segment	____	____	____
☐ 30 Degree Test	____	____	____

Date of Onset: _____

INDICATIONS:

VA: OD: _____ OS: _____

Pressures: OD: _____ OS: _____

DIAGNOSIS: _____

HISTORY: _____

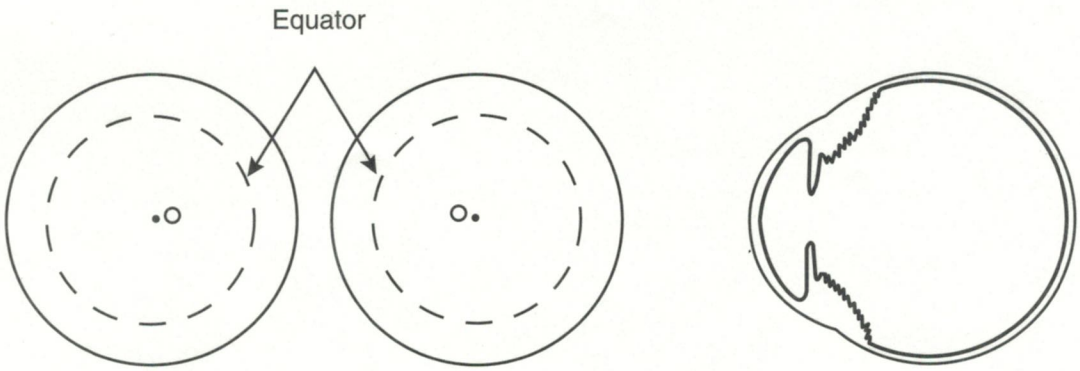
_____

_____

_____

Are there specific questions you want answered? _____

_____



Images reviewed with: _____