UCDAVIS
EYE CENTER

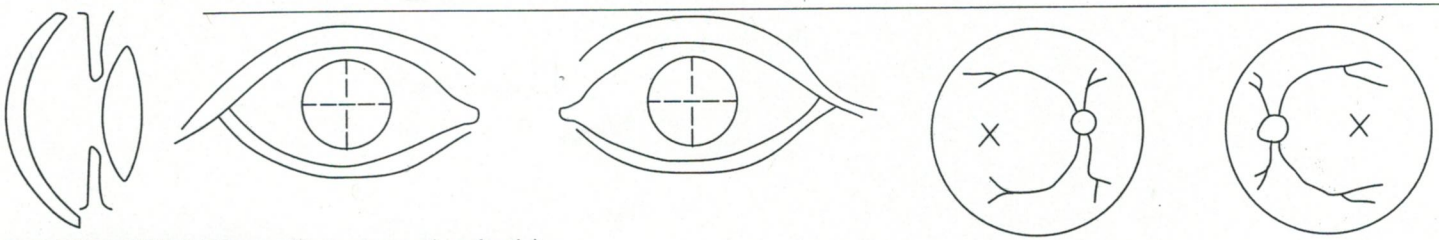
UNIVERSITY OF CALIFORNIA DAVIS
MEDICAL CENTER,
SACRAMENTO, CALIFORNIA

OPHTHALMOLOGY
PHOTOGRAPHY/ANGIOGRAPHY REQUEST/CONSENT

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

TENTATIVE DIAGNOSIS: _____ MEDICATION ALLERGIES: _____

BRIEF HISTORY: _____



PHOTOGRAPHY (Please Circle Areas that Apply)

☐ COLOR FUNDUS PHOTOS:	STEREO	OD	OS	DISC	MACULA			
☐ ICG:	EARLY	OD	OS	DISC	MACULA			
☐ FLUORESCEIN ANGIO:	EARLY	OD	OS	DISC	MACULA			
☐ IRIS ANGIO:		OD	OS	DISC	MACULA			
☐ RED FREE:		OD	OS	DISC	MACULA			
☐ EXTERNAL PHOTOS:	STRAB	SERIES	FULL FACE	2-EYE	OD	OS	OTHER _____	
☐ SLIT LAMP:	OD	OS						
☐ CORNEAL ENDO CELL:	OD	OS						

PREVIOUS ANGIO? NO YES PREVIOUS PROBLEM WITH ANGIO? NO YES _____

PRE VITAL SIGNS: BP _____ P _____ RR _____ IV SITE: _____ DRUG _____

POST VITAL SIGNS: BP _____ P _____ RR _____

COMMENTS: _____

_____ _____

REQUESTING PHYSICIAN SIGNATURE PI#:

_____ _____

☐ nurse ☐ faculty ☐ fellow ☐ resident PI#: