UC DAVIS
EYE CENTER

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Ophthalmology Ultrasound Request Form

Request Date: _____
Patient Name: _____ Sex: _____ DOB: _____

EVALUATE:	OD	OS	OU
☐ A-Scan	___	___	___
☐ B-Scan	___	___	___
☐ Movie Format	___	___	___
☐ UBM Anterior Segment	___	___	___

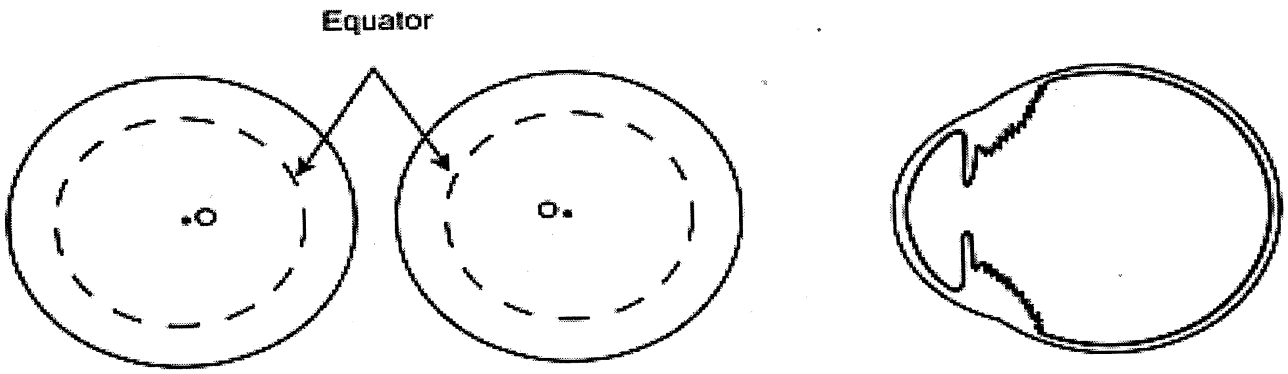
INDICATIONS:

VA: OD: _____ OS: _____
Pressures: OD: _____ OS: _____
DIAGNOSIS: _____

Date of Onset: _____

HISTORY: _____

Are there specific questions you want answered? _____



Images reviewed with: _____