VALLEY EYE ASSOCIATES

REQUEST FOR TESTS AT VALLEY EYE ASSOCIATES

DATE:_____

REFERRING DR: _____ PHONE #: _____

PATIENT NAME: _____ DOB: _____

PATIENT PHONE #: _____

TEST(S) SHOULD BE DONE WITHIN: _____ DAYS _____WEEKS _____ MONTHS

PLEASE PROVIDE GLASSES RX: _____

- ☐ COLOR VISION
- ☐ CORNEAL TOPOGRAPHY
- ☐ ENDOTHELIAL CELL COUNT
- ☐ HUMPHREY FIELDS 30/2
- ☐ HUMPHREY FIELDS OTHER _____
- ☐ O.C.T. – RNFL
- ☐ O.C.T. – MACULA
- ☐ PACHYMETRY
- ☐ RETINAL PHOTOS – MAC
- ☐ RETINAL PHOTOS – OPTIC NERVE
- ☐ WAVESCAN

- ☐ OTHER _____

- ☐ BOTH EYES
- ☐ RIGHT EYE ONLY
- ☐ LEFT EYE ONLY

- ☐ DILATE
- ☐ DON'T DILATE

DIAGNOSIS : ☐ POAG ☐ OCULAR HYPERTENSION ☐ DME

☐ AMD ☐ GLAUCOMA SUSPECT ☐ OTHER _____

**NOTE: "RULE OUT" DIAGNOSIS IS NOT ALLOWED

☐ Send Results to Referring Doctor
☐ Dr Salm ☐ Dr Vrabec ☐ Dr Almond ☐ Dr Smith to Review Results and Consult Referring Doctor
☐ Dr Salm ☐ Dr Vrabec ☐ Dr Almond ☐ Dr Smith to See Patient for Test Results and Consultation

Additional Comments: _____

_____

Please Complete Above Information and Fax To:

VALLEY EYE ASSOCIATES
PHONE #: 920-739-4361
FAX #: 920-739-6368

THANK YOU

06/2026