BLACK HILLS REGIONAL EYE INSTITUTE

2800 Third Street, Rapid City, SD 57701
Local: (605) 341-2000; Toll-Free: (800) 658-3500 Fax: (605) 341-9183 www.blackhillseyes.com

DIAGNOSTIC TESTING ORDER

Referring Doctor:

Copy of test to be: ☐**Mailed** ☐**Faxed**

*If interpretation requested, please schedule evaluation with BHREI physician.

Name:

Address:

Phone: Fax:

Patient Information:

Patient Name	
Date of Birth	
Address	
Phone	
Insurance Co.	
Address	
Phone	
Policy No.	
Group No.	
Policy Holder	
Subscriber's relationship to patient	☐ Female (self) ☐ Male (self) ☐ Female Spouse ☐ Male Spouse ☐ Female child ☐ Male child ☐ Step Child ☐ Foster Child ☐ Other_____

☐**Copy of insurance pre-authorization for requested test attached.**

If minor, Parent/Guardian:

*Parent/Guardian must accompany patient to appointment

Name		Relationship
SSN		
Address		
Phone		

Ocular History:

OD:	Sphere	Cylinder	Axis	VA: /
OS:	Sphere	Cylinder	Axis	VA: /

Diagnostic Test Strategy Requested: ☐**OU** ☐**OD** ☐**OS**

☐**10-2 VF**	☐**24-2 VF**	☐**30-2 VF**	☐**Kinetic VF**	☐**External Photos**
☐ SITA-Fast ☐ SITA-Standard ☐ Fast-Pac, Size I-V___	☐ SITA-Fast ☐ SITA-Standard ☐ Fast-Pac, Size I-V____	☐ SITA-Fast ☐ SITA-Standard ☐ Fast-Pac, Size I-V_____	☐ Single Isopter, Size III4e ☐ Untaped & Taped	☐ Full/Oblique ☐ Lower Lid ☐ Other_____

☐**OCT**	☐**Fundus Photos**	**Do you want the patient dilated** ☐**Yes** ☐**No**
☐ Anterior Segment – 92132 ☐ _____ ☐ Posterior Segment – 92133 ☐ _____ ☐ Retinal – 92134 ☐ _____		**Suggested dilating drops**_____ **Are the angles open** ☐**Yes** ☐**No** **Other**_____

Diagnosis (ICD-10 Code):

PRINTED Signature, Referring Doctor	Signature, Referring Doctor	Date