HOLLINGSHEAD EYE CENTER

360 East Mallard Drive, Suite 110
Boise, Idaho 83706
Ph: 208-336-8700
Fax: 208-426-0902

PHYSICIAN ORDER FOR SPECIAL TESTING

Patient Name: ___________________________________ Appt Date: _____________

Date of Birth: ___________________________________ Appt Time: ____________

Ordering Physician ____

Physicians Signature: ____

❑Test only ❑Test and Interpretation ❑Test and Consultation

Return results via: ❑ Fax # ___________________ ❑ Mail ❑With Patient

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Test Requested: ❑OD ❑OS ❑OU Diagnosis:

- ❑ Visual Field (circle one) ____________
  - o 30-2
  - o 24-2
  - o Red Dot
  - o Bleph
- ❑ OCT ____________
- ❑ OPTOS
- ❑ Orbscan ____________
- ❑ Corneal Topography ____________
- ❑ ECC ____________
- ❑ Other ______________________________ ____________