OPHTHALMIC TEST FORM

This form is interactive. Please complete and return by email to:
info@londonmedical.co.uk or fax to **+44 (0)207 467 5471**

LondonMedical
49 Marylebone High Street, London W1U 5HJ
Tel: **+44 (0)8000 483 330**

PATIENT DETAILS

Title: Mr/Mrs/Miss/Ms/Other:

Name:

DOB: Sex: M F

Address:

Post Code:

Phone number:

PID (London Medical use):

REFERRING CLINICIAN

Name:

Address:

Post Code:

Phone number:

Fax number:

Email:

Referrer's signature (REQUIRED) **Date**

RESULTS TO (please specify)

Patient ☐	Hardcopy ☐	Post ☐
Clinician ☐	CD ☐	Pick up ☐

Relevant medical history (please specify – current medical conditions, medications and any allergies)

Referral information (please select tests required)

Visual Fields

30-2 ☐ 24-2 ☐
10-2 ☐ Esterman ☐

Other (please specify)

IOL Biometry ☐
Default target refraction = 0

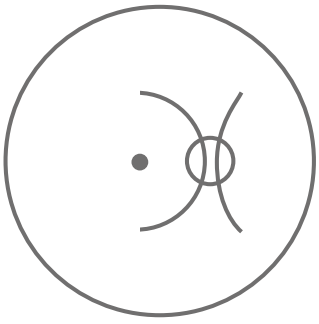
Other target refraction (please specify)
Right eye: _____
Left eye: _____

Corneal topography ☐
Comments:

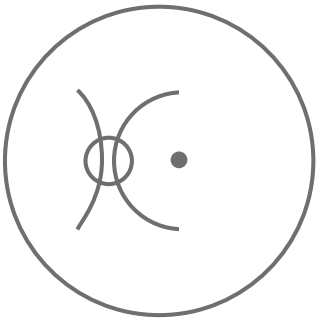
Pachymetry ☐
Comments:

OCT
Macula ☐ EDI ☐ RNFL ☐
Comments:

RE



LE



It may not be possible to carry out FFA, ICGA and Photography on patients diagnosed with or suspected Narrow Angles and/ or Closed Angle Glaucoma due to required dilation.

Fundus photography
Macula ☐ Disc ☐ Survey ☐
Comments:

Fluorescein angiography
Topcon ☐ Heidelberg ☐
Run on / Transfer, which eye first?
Right ☐ Left ☐
Comments:

Indocyanine Green angiography
Heidelberg *only*
Run on / Transfer, which eye first?
Right ☐ Left ☐
Comments: