BLACK HILLS REGIONAL EYE INSTITUTE
2800 Third Street, Rapid City, SD 57701
Local: (605) 341-2000 Toll-Free: (800) 658-3500 Fax: (605) 341-0278 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	Social Security Number
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