Patient Name:

DOB:

MR #:

When UWH Provider is Ordering, Index to Physician Orders
When Outside Provider is Ordering, Index to Consult/Referral/Transfer

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

ORDER REQUEST FOR VISUAL FUNCTION STUDIES

Date: _____

Visual Function Study Requests: This form needs to be completed by referring providers from outside the UW Health System and faxed to (608) 263-4247. For scheduling and questions please call (608) 263-6414.

Step 1: Prior to faxing the clinic, please make sure patient is registered in the UW Health System: 1-800-303-6114

Step 2: Please send the following information, if completed by the patient:

Item Required	Records Available (circle one)		Required Methods for Sending Individual Items to UW Health
Previous Ophthalmic Clinic Notes	Yes	No	Please fax to (608) 263-4247
Fundus Photos, Fundus Autofluorescence (FAF) Photos and Optical Coherence Tomography (OCT)	Yes	No	Please mail color Photos/FAF/OCT on CD or print University Station Clinic Attn: ERG/VEP 2880 University Ave, Madison, WI 53705
Visual Field Testing	Yes	No	Please fax to (608) 263-4247 or mail to above address

Step 3: Referring provider and patient information **(please print)**:

Referring provider name: _____ Contact person: _____ Care Everywhere: Yes No

Clinic phone: _____ Clinic fax: _____Insurance referral date: _____

Patient name: _____ Parent or guardian: _____

Patient address: _____

Patient date of birth: _____ Patient phone number: _____

Step 4: Please check appropriate box or boxes below.

Complete consultation with	☐ Retina Specialist	☐ Neuro- Ophthalmologist	☐ Second Opinion

☐ Test Only (with interpretation): **Please check appropriate box or boxes below.**
*****Please allow 2 hours for an ERG and 1-2 hours for a VEP*****

☐ Electroretinogram (ffERG) with DA	☐ 100- hue color test (Farnsworth)	☐ Sweep (objective test for acuity)
☐ Multifocal ERG (mfERG)	☐ Lantern test	☐ Flash (fVEP basic test)
☐ Pattern ERG (pERG)	☐ Albinism 4 Channel (45-mins test time)	☐ Pattern (PVEP macular test)
☐ Electro-Oculogram (EOG)	☐ Multifocal VEP (mfVEP done with ERG lab)	

Brief History and Clinical Findings: Best corrected visual acuity: Right eye: _____ Left eye: _____

Glasses prescription: Right eye: _____ Left eye: _____

Patient complaint: _____

Diagnosis: _____

Clinical findings: _____

Medications: _____

_____

Special Instructions/Timeframe: _____

Provider Signature: _____ Date: _____/_____/_____Time: _____ Pager #: _____