WADZINSKI EYE CLINIC
CENTER FOR RETINA EYE CARE

Request for Diagnostic Testing

Referring Doctor: _____

Patient Name: _____

Appointment Date/Time: _____

Diagnostic Test Requested:

Visual Field Testing:

- Blepharoplasty
- Glaucoma 24-2 30-2 Sita Fast Standard
- Other _____

OCT:

- Optic Nerve
- Macula

Other: Please Specify _____

Comments:

_____

_____

Phone (712)226-3937 **Toll Free (800)572-1249** **Fax (712)224-3973**