EYE CARE OF DELAWARE LLC

Test Order

Name: _____ Appointment Date: _____

Patient Phone #:_____ Date of Birth: _____

Referring Doctor:_____ Eye(s) Tested: OD OS OU

Test	**CPT/Diagnosis Code**		
B-Scan	76512	Diagnosis:_____	Diagnosis Code:_____
OCT – Macula	92134	Diagnosis:_____	Diagnosis Code:_____
OCT – Optic Nerve	92133	Diagnosis:_____	Diagnosis Code:_____
OCT – Anterior Seg	92132	Diagnosis:_____	Diagnosis Code:_____
OPD		Diagnosis:_____	
Visual Field 30-2 24-2 10-2			
Threshold	92083	Diagnosis:_____	Diagnosis Code:_____
Screening	92082	Diagnosis:_____	Diagnosis Code:_____
Pachymetry OD ____OS____	76514	Diagnosis:_____	Diagnosis Code:_____
Corneal Topography	92025	Diagnosis:_____	Diagnosis Code:_____
Inflammadry	83516	Diagnosis:_____	
Dry Eye Test (TearLab)	83861	Diagnosis:_____	
		Dry eye syndrome	Diagnosis Code: H04.12( )
		Keratoconjunctivitis sicca	Diagnosis Code: H16.22( )
		Sjogren's disease	Diagnosis Code: M35.01
Allergy Testing (DoctoRx's Allergy)	95004	Diagnosis:_____	
		Chronic allergic conjunctivitis	Diagnosis Code: H10.45( )
		Acute atopic conjunctivitis	Diagnosis Code: 372.05

Optometrist's Signature:_____