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:_____	
Fundus Photography	92250 Diagnosis:_____	Diagnosis Code:_____
Visual Field 30-2 24-2 10-2		
Threshold	92083 Diagnosis:_____	Diagnosis Code:_____
Screening	92082 Diagnosis:_____	Diagnosis Code:_____
Pachymetry	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

Doctor's Signature:_____ Date: _____

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