IWK Health Center, Eye Care Team
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Referral Submission: emily.radford@iwk.nshealth.ca
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Visual Electrophysiology Laboratory Referral

Patient Details

Name (*last/first*): **DOB** MM-DD-YYYY

Address:

Phone:

Sex: ☐ M ☐ F ☐ Other **Health Card:**

Referring Physician

Name: **Billing Number:**

Phone: **Fax:**

Priority: ☐ Follow up ☐ Routine ☐ Urgent **Signature:**

Procedure(s) Requested (*if unsure lab will determine by diagnosis/investigation*)

☐ Visual Evoked Potential (VEP)
☐ Electroretinogram (ERG)
☐ Dark Adaptometry
☐ Multi-channel VEP
☐ Multifocal ERG (mfERG)
☐ Color /Contrast
☐ Pattern ERG (PERG)
☐ Electro-oculogram (EOG)
☐ Other (insert below)

Other:

Visual Acuity:

RE

LE

Safe to dilate?

☐ Yes
☐ No

Visual Fields:

☐ Constricted
☐ Scotoma
☐ Macular Defect
☐ Normal

Optical Media:

☐ Clear
☐ Cataracts
☐ RE ☐ LE

Diagnosis/Investigation:

Fundus findings: Normal Retina Normal Optic Nerve