

ASSOCIATED EYE CARE, INC.

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(419) 696-7782 fax

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Suite 100
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960 W. Wooster St.
Suite 216
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(419) 352-5500
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REQUEST FOR DIAGNOSTIC TESTING

NAME: _____

D.O.B.: _____

DATE: _____

DIAGNOSIS: _____

- | | |
|---|--|
| <input type="checkbox"/> ACE LEVEL | <input type="checkbox"/> PROTEIN "C" |
| <input type="checkbox"/> ANA | <input type="checkbox"/> PROTEIN "S" |
| <input type="checkbox"/> ANCA | <input type="checkbox"/> RHEUMATOID FACTOR |
| <input type="checkbox"/> ANTICARDIOLIPIN ANTIBODY | <input type="checkbox"/> SERUM LIPIDS- FASTING |
| <input type="checkbox"/> BLOOD SUGAR (FBS) | <input type="checkbox"/> TSH |
| <input type="checkbox"/> BUN, CREATININE, GFR | <input type="checkbox"/> T3 |
| <input type="checkbox"/> "C" REACTIVE PROTEIN | <input type="checkbox"/> T4 |
| <input type="checkbox"/> SED RATE – WESTERGREN | <input type="checkbox"/> WBC |
| <input type="checkbox"/> CBC WITH DIFF | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> CHEST X-RAY | |
| <input type="checkbox"/> CT SCAN WITH AND WITHOUT CONTRAST | |
| <input type="checkbox"/> CT SCAN WITHOUT CONTRAST | |
| <input type="checkbox"/> FACTOR 5 LYDEN | |
| <input type="checkbox"/> FTA ABS | |
| <input type="checkbox"/> RPR | |
| <input type="checkbox"/> VDRL | |
| <input type="checkbox"/> Hgb A1c | |
| <input type="checkbox"/> HLA-B 27 | |
| <input type="checkbox"/> LYME TITER | |
| <input type="checkbox"/> LYSOZYME | |
| <input type="checkbox"/> MRA | |
| <input type="checkbox"/> MRI WITH AND WITHOUT CONTRAST-BRAIN | |
| <input type="checkbox"/> MRI WITHOUT CONTRAS-BRAIN | |
| <input type="checkbox"/> MYASTHENIA RECEPTOR ANTIBODY-BINDING, BLOCKING, MODULATING | |
| <input type="checkbox"/> PLATELETS | |
| <input type="checkbox"/> PPD | |

SIGNATURE _____

K. Charles Raffoul, M.D.
Dino J. Costa, O.D.

Christina P. Tam, M.D.
Carol J. German, O.D.

James A. Knupp, M.D.

Anjali Tapadia, M.D.
John M. Elchinger, O.D.