

ASSOCIATED EYE CARE, INC.

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(419) 352-5500
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REQUEST FOR DIAGNOSTIC TESTING

Name _____

D.O.B. _____

Date _____

Diagnosis _____

- _____ ACE LEVEL
- _____ ANA
- _____ ANCA
- _____ ANTICARDIOLIPIN ANTIBODY
- _____ BLOOD SUGAR (FBS)
- _____ BUN
- _____ "C" REACTIVE PROTEIN
- _____ CBC
- _____ CHEST X-RAY
- _____ CRIT
- _____ CT SCAN WITH / WITHOUT CONTRAST
- _____ FACTOR 5 LYDEN
- _____ FTA
- _____ Hgb A1c
- _____ HLA-B 27
- _____ LYME TITER
- _____ LYSOZYME
- _____ MRA
- _____ MRI WITH / WITHOUT CONTRAST
- _____ MYASTHENIA RECEPTOR ANTIBODY
- _____ PLATELETS
- _____ PPD
- _____ PROTEIN "C"
- _____ PROTEIN "S"

- _____ RHEUMATOID FACTOR
- _____ RPR
- _____ SED RATE - WESTERGREN
- _____ SERUM LIPIDS
- _____ TSH
- _____ T3
- _____ T4
- _____ VDRL
- _____ WBC
- _____ OTHER
- _____
- _____
- _____

SIGNATURE _____

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