

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: SKEW DEVIATION H51.8, MYASTHENIA GRAVIS G70.01, ANEMIA D64.9, DIABETES E11.9, CHOLESTEROL E78.0, RENAL INSUFFICIENCY N28.9, TEMPORAL ARTERITIS M31.6

- | | |
|---|--|
| <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 _____