

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, RENAL INSUFFICIENCY N28.9, TEMPORAL ARTERITIS M31.6,
TIA H34.01; H34.02, CN 3 PALSY H49.0, CN 4 PALSY H49.1, CN 6 PALSY H49.2,
PITUITARY TUMOR D35.2, CEREBRAL ANEURYSM, NONRUPTURED I67.1,
CHOLESTEROL E78.0, CNS VASCULITIS I68.2

CLINICAL HISTORY: _____

- _____ BUN, CREATININE, GFR
- _____ CT SCAN WITH AND WITHOUT CONTRAST- BRAIN
- _____ CT SCAN WITHOUT CONTRAST- BRAIN
- _____ CTA WITH CONTRAST- HEAD
- _____ CTA WITH CONTRAST- NECK
- _____ MRA WITH CONTRAST- BRAIN
- _____ MRA WITHOUT CONTRAST- BRAIN
- _____ MRI WITH AND WITHOUT CONTRAST- BRAIN
- _____ MRI WITHOUT CONTRAST- BRAIN
- _____ CAROTID ULTRASOUND- NECK
- _____ CHEST X-RAY
- _____ OTHER _____

SIGNATURE _____

K. Charles Raffoul, M.D. Christina P Tam, M.D. James A Knupp, M.D.

Dino J Costa, O.D. John M Elchinger, O.D.