BC Children's Hospital
Provincial Health Services Authority

***Department of Ophthalmology***
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***Booking Phone Line: 604-875-2111***
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NAME:
DOB:
GENDER: M ☐ F ☐ Other:
PREFERRED PRONOUNS:
PHN:
PHONE NUMBER:

Translator Required? : Yes ☐ No ☐
Language:

# REQUISITION FOR VISUAL ELECTROPHYSIOLOGY

*(To be completed fully and legibly by referring physician)*

| | |
|---|---|
| ☐ **Full-Field ERG** | ☐ **EOG** |
| ☐ **Multi-Focal ERG** | ☐ **Pattern Reversal VEP** |
| ☐ **Pattern ERG** | ☐ **Flash VEP** |

**RELATED HISTORY** *(MUST BE COMPLETED)*

**CLINICAL HISTORY / FOLLOW UP FREQUENCY**

_____

_____

**MEDICATIONS**:_____

**CLINICAL PRIORITY:** ☐ Urgent ☐ Elective

**SEDATION REQUIRED:** ☐ No ☐ Yes

| | Distance Refraction | Visual Acuity |
|---|---|---|
| **RE** | | |
| **LE** | | |

**Physician's orders:**

1. **For dilation:** Phenylephrine 2.5%, Mydriacyl 1%, Cyclopentolate 1%, 1 drop in both eyes
   **Children <2 years old:** Phenylephrine 1.25%, Cyclopentolate 0.5%, 1 drop in both eyes
2. Alcaine 0.5% 1 drop both eyes, PRN

**PLEASE ATTACH THE MOST RECENT CONSULT NOTE TO THIS REQUISITION**

**REFERRING PHYSICIAN** *(MUST BE COMPLETED)*

| | | | |
|---|---|---|---|
| **Name** | | **Phone** | |
| **MSP #** | | **Fax** | |
| **Signature** | | **Address** | |