|  |  |
| --- | --- |
| C:\Users\yumang\AppData\Local\Temp\1\Temp1_RGB-screen.zip\RGB (screen)\JPG\CEI-1CBLACK-POS.jpg**Oregon Health & Science University**  **Casey Eye Institute – Ultrasound Service**  **Ophthalmic Ultrasound Request**  Please fax to number below  *P: 503-494-6795 F: 503-494-5188* | NAME Click or tap here to enter text.  BIRTHDATE Click or tap here to enter text.  *Patient Identification* |
| **Indication:** Click or tap here to enter text.   |  |  | | --- | --- | | **B-scan:**  OD  OS  OU | **B-scan with Diagnostic A-scan:**  OD  OS  OU | | **Ultrasound Biomicroscopy:**  OD  OS  OU | **Axial Length (immersion):**  OD  OS  OU |   **COMMENTS:**  Click or tap here to enter text.  **vancouver_eye.tif**  Physician: Click or tap here to enter text.  Instructions for follow-up: Click or tap here to enter text.  Signature: | | |