Flaum Eye Institute at the University of Rochester

AScan & IOLMaster Form (Outside Referrals)

Initials: ________________

Patient Name: ______________________
DOB: ______________________
Diagnosis: ______________________

REFERRING DR: ______________________
ADDRESS/OFFICE: ______________________
____
OFFICE PHONE: ______________________
FAX #: ______________________

Need all information above before we can proceed with testing. Please fill out all items in the left column below.

**Items below can be faxed if indicated. Please provide a FAX number if requesting results to be faxed.

IOLMaster & A & BScan *(ASC)* **TECH:**	**Master Charge Code (1516)**		
	Right	**Left**	**Bilateral**
☐ **Only do OD** ☐ **Only do OS** ***(ASC)*** *(both eyes done unless otherwise indicated)*	IOLMaster only w/IOL calc. ☐ 0424*RT CPT 92136	IOLMaster only w/IOL calc. ☐ 0424*LT CPT 92136	IOLMaster only w/IOL calc. ☐ 0424 CPT 92136
☐ **IOLMaster and/or AScan (ASC)** ☐ Surgery type: __________ ☐ Surgical Eye: ☐ OD ☐ OS ☐ Target ref if other than plano: __________ ☐ Use assumed K's of 45 ☐ OD ☐ OS	AScan & IOLMaster w/IOL calc ☐ 0456*RT CPT 76519	AScan & IOLMaster w/IOL calc ☐ 0456*LT CPT 76519	AScan & IOLMaster w/IOL calc ☐ 0456 CPT 76519
Please indicate any necessary settings, other than phakic: ☐ Aphakic setting: ☐ OD ☐ OS ☐ Pseudophakic setting: ☐ OD ☐ OS Type of IOL *(silicone, PMMA, etc, if known. If type of IOL NOT known, use PMMA):* __________ ☐ Silicone Oil: ☐ OD ☐ OS	AScan – axial length, no IOL calc ☐ 0300*RT CPT 76511	AScan, axial length, no IOL calc. ☐ 0300*LT CPT 76511	AScan – axial length, no IOL calc. ☐ 1300*50 CPT 76511
Please list any other previous surgeries or known eye conditions on both eyes below to help ensure good results: (ie. S/P PK, S/P Scleral Buckle, Corneal Dystrophy, S/P LASIK, etc.): **B-SCANS Must be scheduled with our Retinal Services. Please call 273-3937 to schedule an appointment with one of our retinal doctors.*			

IOLMaster/AScan Interpretation	OD	OS
ASC IOL	☐ Normal axial Length ☐ Shorter than average length ☐ Longer than average length ☐ Axial length consistent with findings	☐ Normal axial Length ☐ Shorter than average length ☐ Longer than average length ☐ Axial length consistent with findings
☐ **If interpretation was done on print-out, physician has attached print-out to this form**		**SIGNATURE:**

ICD-9 Codes for IOLMaster, A-Scan, B-Scan and Color Vision (I=IOL, A=A-Scan, B=B-Scan)

Macular/Retinal/Vitreous disease

☐ Myopic degeneration	B		360.21
☐ Vitreous degeneration	B		379.21

Retinal Detachment/Schisis

☐ Choroid detach, unspecified	B		363.70
☐ Retinal detachment, NOS	B		361.9

Uveitis/Infection

☐ Acute endopthalmitis	B		360.01
☐ Chronic endopthalmitis	B		360.03
☐ Infection/Inflammatory reaction 2⁰ other internal prosthetic device implant and graft	A	I	996.69

Neoplasms

☐ Tumor unspecif, malignant	B	190.9
☐ Tumor unspecified, benign	B	224.9

Glaucoma

☐ Anatomical narrow borderline	B	365.02

Neuro

☐ Drusen of optic disc	B	377.21

Cornea

☐ Corneal edema, unspecified	B	371.20
☐ Corneal opacity, unspecified	B	371.00
☐ Phthisical cornea	B	371.05

Anterior Chamber/Adenxa

☐ Exopthalmos, unspecified	B	376.30
☐ Hyphema, iris/ciliary body	B	364.41
☐ Microphthalmos unspecified	B	743.10
☐ Orbit atrophy	B	376.45
☐ Orbital cellulitis	B	376.01
☐ Orbital enlargement	B	376.46

Foreign Body

☐ In anterior chamber	B	360.61
☐ In iris or ciliary body	B	360.62
☐ In vitreous	B	360.64

Other: ______________________

Lens

☐ After cataract, unspecif	B		366.50
☐ Aphakia	A	I	379.31
☐ Ant. dislocation of lens	A	I	379.33
☐ Cataract, unspecified	A, B, I		366.9
☐ Cataract nonsenile unsp	A, B, I		366.00
☐ Cataract senile unspecif	A, B, I		366.10
☐ Congenital Cataract uns	A, B, I		743.30
☐ Post. dislocation of lens	A	I	379.34
☐ Pseudoexfoliation lens	A, B, I		366.11
☐ Subluxation of lens	A	I	379.32
☐ Mechanical Comp of IOL	A	I	996.53

Pt. Location:	☐ Cornea waiting room	☐ Mixed services waiting room	☐ Neuro/Glaucoma waiting room	☐ Retina/comp waiting area
	☐ Peds waiting room	☐ Clinic waiting room	☐ Exam room: __________	☐ Other: __________
When done:	☐ Pt. to see doctor	☐ Pt check-out (3rr floor/ground/Clinic)	☐ Surgical Sch: __________	☐ Other: __________

Original copy for outside referrals (Faxing/Mailing form)