



# Visual Electro-Diagnostic Clinic

Eye-Tech Southside  
22 Sanders St  
Upper Mt Gravatt Q 4122  
Ph: 07 3420 4899  
Fax: 07 3349 7260  
erg@eyedr4kids.com

Phone for Appointments 07 3420 4899

## REQUEST FORM FOR TESTS

Patient Name: .....Date of Birth: .....

Patient Phone: .....

Clinical Details: Best Corrected VA Right ..... VA Left .....

Visual Fields: .....

History & Examination: .....

.....

.....

P.D. ....

- |                         |                             |           |                          |
|-------------------------|-----------------------------|-----------|--------------------------|
| <b>Tests Requested:</b> | Electroretinogram           | (ERG)     | <input type="checkbox"/> |
|                         | Electrooculogram            | (EOG)     | <input type="checkbox"/> |
|                         | Pattern ERG                 | (PERG)    | <input type="checkbox"/> |
|                         | Visually Evoked Potential   | (VEP)     | <input type="checkbox"/> |
|                         | Visual Acuity*              | (AVEP)    | <input type="checkbox"/> |
|                         | Multifocal ERG              | (MFERG)   | <input type="checkbox"/> |
|                         | Multifocal VEP              | (MFVEP)   | <input type="checkbox"/> |
|                         | Colour Vision -FM           | (100 Hue) | <input type="checkbox"/> |
|                         | Clinical Review Requested** |           | <input type="checkbox"/> |

\* An updated test Jan 2008;

\*\* When possible all patients will be reviewed at the time of the tests

Name of Referrer: .....Provider No: .....

Signature: ..... DATE: .....

Email Address for Report: .....



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## indications for specific tests

<i>Provisional Diagnosis</i>	<i>EOG</i>	<i>ERG</i>	<i>Bright Flash ERG</i>	<i>PERG</i>	<i>Flash VEP</i>	<i>Pattern VEP</i>	<i>Special VEP</i>	<i>mfERG</i>	<i>mfVEP</i>
Inherited retinal dysatrophies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Vascular Diseases incl Diabete	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Opaque Media /trauma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RetroBulbar Neuritis*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Unexplained Visual Loss	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infancy ? Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Albinism	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toxic & Nutritional eye disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Suspected Intracranial lesion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**Getting there:** Ground Floor (parking under),  
 Eye-Tech Southside  
 22 Sanders St

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Upper Mt Gravatt, Brisbane

