BC CHILDREN'S HOSPITAL

Department of Ophthalmology

Shaughnessy Building, off Heather St. Entrance #73
4480 Oak Street
Vancouver, BC V6Z 1Y6
Lab Phone line: 604-875-2345 Extension#7849
Booking Phone Line: 604-875-2372
FAX: 604-875-3561

NAME:
DOB:
GENDER: M / F
PHN:
ADDRESS:

PHONE NUMBER:
Translator Required? : N / Y
Language:_____

REQUISITION FOR VISUAL ELECTROPHYSIOLOGY

(To be completed fully and legibly by referring physician)

Appointment Date:_____ Time:_____
(Patient should arrive promptly or they may not receive the complete test)

ERG ☐ **EOG** ☐ **mfERG** ☐

Pediatric Pattern VEP ☐ *(Adult VEPs are performed in the EEG depart.at VGH 604-875-4400)*

RELATED HISTORY (MUST BE COMPLETED)

Reason for request/brief history

_____

_____

Medications:_____

Cooperative? ☐ **Sedation Required?** ☐ **Additional Note**:_____

	Distance Refraction	**Visual Acuity**
RE		
LE		

REFERRING PHYSICIAN (MUST BE COMPLETED)

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