

SPECIAL PROCEDURES REPORT

Patient Name: _____

FOR TESTING PERFORMED _____

DATE

REVIEWED/SIGNED

Humphrey Visual Field for: _____
OD: _____
OS: _____
Disposition: _____

External Photos for: _____
OD: _____
OS: _____
Disposition: _____

Fundus / Disc Photos for: _____
OD: _____
OS: _____
Disposition: _____

Fluorescein Angiography OD → OS
for: _____ OS → OD
OD: _____
OS: _____
Disposition: _____

B-scan for: _____
OD: _____
OS: _____
Disposition: _____

Glare Low ___ Moderate ___ High ___ Intensity
OD: _____
OS: _____