SCANLY®
HOME OCT Monitoring Program

Concierge Service
Provided by Notal Vision
Monitoring Center

PHYSICIAN ORDER FORM

All fields are mandatory if applicable

PATIENT INFORMATION

Gender: ☐ Female ☐ Male D.O.B. _____ MRN _____

_____

Last Name First Name Middle Initial

Cell Phone (preferred): _____

Home Phone (landline): _____

Email Address:

_____

Delivery Address City State Zip

SCANLY Monitoring Program is indicated for patients with neovascular AMD in at least one eye.

Please select the Wet AMD Eye(s):

◯ OD - Right ◯ OS - Left ◯ OU - Bilateral

Enter the Wet AMD ICD-10 Code(s):

OD Select from dropdown OS Select from dropdown Bil. Select from dropdown

Enter Other ICD-10 Code(s) for these eye(s), as needed:

OD OS

Select the eye(s) to be monitored with SCANLY Monitoring Program:

◯ OD - Right ◯ OS - Left ◯ OU - Bilateral

☐ I confirm that eyes selected to be monitored have visual acuity 20/320 or better.

ORDERING PHYSICIAN INFORMATION/SIGNATURE

_____

Print Physician Name Physician Signature & Date

_____

Practice Name Office Location Practice Phone Number

The Notal Vision Monitoring Center is a healthcare provider and an IDTF HIPAA covered entity. Dedicated to maintaining privacy and security, patient's health information can be shared between the referring physician and HIPAA covered entities. As the referring provider, I acknowledge that I have read and understand the "Notal Vision Diagnostic Test Service Physician/Practice Responsibilities" online and hereby attest that the information contained in this order is accurate and correct.

Submit this form by fax to 1-888-341-9400. *For assistance please call 1-866-203-1188.*