CONSULTATION REQUEST

Date: _____

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P: (724)347-5665
F: (724)347-5706

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Greenville, PA
P: (724)589-5665
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PATIENT NAME: _____ DOB: _____

HOME PHONE: _____ CELL PHONE: _____

☐ Cataract
☐ PCO/YAG Evaluation
☐ Narrow Angles/LPI
☐ SLT
☐ Glaucoma Evaluation
☐ Cornea Evaluation

☐ Eyelid/Oculoplastics *(Boardman only)*
☐ Dry Eye
☐ Red Eye
☐ Flashes/Floaters
☐ Visual Field Defect

☐ Reduced Vision
☐ Diplopia
☐ Other: _____
_____
_____

☐ Testing Only / No Exam: List Below
_____
_____

Please provide refractive error and BCVA

OD: _____ 20/

OS: _____ 20/

Any history of contact lens wear? Yes / No

Type: RGP / Soft Multifocal: Yes / No

Monovision Yes / No Near Eye: OD OS

For glaucoma consults, please provide any available information such as pre-treatment IOP, most recent IOP, previous and current glaucoma meds, C/D ratio, pachymetry, threshold visual fields, OCT scans

Additional Pertinent Information:

_____
_____
_____
_____

☐ **CONSULTATION REQUEST** Please evaluate, consider treatment, and/or render your opinion regarding this patient's ocular condition. I look forward to receiving your opinion and will resume general eye care following your consultation.

☐ **TRANSFER OF CARE:** Please evaluate, treat and assume further care for this patient.

Referring Doctor's Signature: _____ Referring Doctor: _____

Office Phone Number: _____ Office Fax: _____

Please fax all consult requests to the office where you would like the patient to be evaluated at. Thank you.