

**REQUEST FOR CONSULTATION WITH:**

Hendersonville: 828-693-1773 • Fax: 828-692-3297

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Columbus: 828-894-3037 • Fax: 828-894-5525

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Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Last Exam: \_\_\_\_\_

Chief Complaint/History: \_\_\_\_\_

Reason for Consultation: \_\_\_\_\_

**REFRACTION**

OD \_\_\_\_\_ X \_\_\_\_\_ 20/ \_\_\_\_\_ Add \_\_\_\_\_ J \_\_\_\_\_

OS \_\_\_\_\_ X \_\_\_\_\_ 20/ \_\_\_\_\_ Add \_\_\_\_\_ J \_\_\_\_\_

Present Glasses: OD \_\_\_\_\_ X \_\_\_\_\_ OS \_\_\_\_\_ X \_\_\_\_\_ Add \_\_\_\_\_

Visual Fields: OD \_\_\_\_\_ OS \_\_\_\_\_ (PLEASE ATTACH)

Pupils: Marcus Gunn Yes  No  Applanation Tonometry: OD \_\_\_\_\_ OS \_\_\_\_\_

**Slit Lamp Findings:**

OD \_\_\_\_\_

OS \_\_\_\_\_

**Fundus Findings:**

OD \_\_\_\_\_

OS \_\_\_\_\_

**Explanation given to patient:**

Cataracts  Retina  Cornea  Glaucoma  Plastics  Other: \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Date \_\_\_\_\_