

REQUEST FOR CONSULTATION WITH:

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Toll Free: 800-624-6575

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 _____