Consultation Request

Suggested for conditions and treatment other than cataract and refractive surgery

I am sending this patient for consultation. Please evaluate and treat as appropriate. I look forward to your opinion and will resume general care following your consultation.

REFERRING DOCTOR

Name ____________________

Address ____________________

____

Phone (____)____________ Referral Date ____________

PATIENT INFORMATION

Name ____________________

Address ____________________

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Phone: Hm (____)____________ Wk (____)____________

Reason for consultation request: ____________________

Chief visual complaint: ____________________

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	OD	**OS**
Best Corrected VA *(date ____________)*	20 / ______	20 / ______
Refraction *(date ____________)*	____________ 20 / ______	____________ 20 / ______
IOP: ☐ Air ☐ Applanation ☐ Other	____________ mm Hg	____________ mm Hg

Visual field enclosed: ☐ Yes ☐ No

Pertinent exam findings: ____________________

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Your recommendations to patient: ____________________

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Appointment:

☐ I have scheduled this patient to be seen at PCLI on: (date) ____________ at (time) ____________ .

☐ I would like PCLI to phone this patient to schedule an appointment.

Signed ____________________
Referring Doctor