Consultation Request

ChuVision INSTITUTE

REFERRING DOCTOR

Name_____

Phone_____

Location_____

Date of Exam_____

PATIENT INFORMATION

Name _____

Address _____

_____

Date of Birth _____

Home Phone _____ Cell_____

REASON FOR CONSULTATION: ☐Cataract Evaluation ☐YAG Laser Evaluation ☐Other_____

☐OD ☐OS ☐OU

For Cataract Evaluation, Please Provide (if available)

Recommended refractive error outcome: ☐ OD_____ ☐ OS_____

K's: OD_____X_____ OD_____X_____

_____X_____ _____X_____

	BAT	Low	Medium	High
OD	20/		20/	20/
OS	20/		20/	20/

IOL Options Discussed ☐ Yes ☐No

Notes: _____

_____

☐Soft lens wearer ☐RGP lens wearer ☐Monovision _____ is the near eye.

CLINICAL FINDINGS	**OD**	**OS**
Dominant eye	☐	☐
Current glasses:	_____20/_____	_____20/_____
Refraction (Date _____)	_____20/_____	_____20/_____
IOP: ☐AIR ☐Applanation ☐Other	_____mm Hg	_____mm Hg

Relevant exam findings _____

_____

_____

Recommendation to patient _____

_____

_____

Appointment

☐ I have scheduled this patient to be seen at CVI on: (date) _____ at (time) _____

☐ I would like CVI to contact this patient to schedule an appointment.

☐ Contact patient about possible CVI transportation. The patient understands this service is limited to surgery patients with transportation challenges and who qualifies under the CVI transportation policy.

Date Sent _____ **Signed** _____

Referring Doctor

CVI Phone 952.835.1235

Fax to CVI at 952.835.0534

Electronic forms are available at www.chuvision.com/eyecare-professionals