General Consultation Request

ChuVision INSTITUTE

REFERRING DOCTOR

Name_____

Phone_____

Location_____

Date of Exam_____

PATIENT INFORMATION

Name _____

Date of Birth _____

Home Phone _____ Cell_____

Email _____

REASON FOR CONSULTATION: _____

_____

_____

_____

CLINICAL FINDINGS	**OD**	**OS**
Dominant eye	☐	☐
Current glasses:	_____20/_____	_____20/_____
Refraction (Date _____)	_____20/_____	_____20/_____

Relevant exam findings _____

_____

_____

_____

Recommendation to patient _____

_____

_____

_____

PLEASE INCLUDE A COPY OF YOUR EXAM WITH THIS SUMMARY

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