Vitreolysis Consultation Request

ChuVision INSTITUTE

REFERRING DOCTOR

Name_____

Phone_____

Location_____

Date of Exam_____

PATIENT INFORMATION

Name _____

Address _____

_____

Date of Birth _____

Home Phone _____ Cell_____

Patient Visual Complaints/Symptoms: _____

Eye: ☐ OD ☐ OS ☐ OU **How long has patient been experiencing floaters: _____**

Activities of Daily Living Affected by Floaters: _____

CLINICAL FINDINGS:

Visually Significant Floaters: ☐ **OD** ☐ **OS** ☐ **OU**

☐ History of PVD ☐ OD ☐OS

Patient is: ☐ Phakic ☐ Pseudophakic: Date of IOL sx _____

☐ Visually Significant PCO ☐ No ☐Yes: ☐ OD ☐OS

Describe Floater: ☐ Weiss Ring ☐ Amorphous Cloud ☐ Fibrous Strands

Location: ☐Central ☐ Inferior ☐ Superior ☐ Nasal ☐ Temporal

Fundus: ☐ Normal ☐ Pathology_____ ☐Other _____

Notes and other 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 877.816.5016

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