Meadville/Valley Ophthalmology Associates

CONSULTATION REQUEST

Date: _____

DONALD SANTORA, MD ROBERT STEIN, DO NICHOLAS FLEBOTTE, OD, FAAO MATTHEW GRIFFITH, OD TAYLOR RUPERT, OD

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Meadville, PA 16335
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Farrell, PA 16121
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PATIENT NAME: _____ DOB: _____

HOME PHONE: _____ CELL PHONE: _____

☐Cataract
☐PCO/YAG Evaluation
☐Narrow Angles/LPI
☐SLT
☐Glaucoma Evaluation
☐Refractive Surgery Consult

☐Refractive Surgery Consult
☐Diplopia
☐Dry Eye
☐Red Eye
☐Flashes/Floaters
☐Visual Field Defect

☐Other:
_____
_____
_____
☐Testing Only / No Exam: List Below
_____
_____

Please provide refractive error and BCVA

OD: _____ 20/

OS: _____ 20/

Any history of contact lens wear? Yes / No

Type: RGP / Soft Multifocal: Yes / No

Monovision Yes / No Near Eye: OD OS

For glaucoma consults, please provide any available information such as pre-treatment IOP, most recent IOP, previous and current glaucoma meds, C/D ratio, pachymetry, threshold visual fields, OCT scans

Additional Pertinent Information:

_____

_____

_____

_____

☐ **CONSULTATION REQUEST** Please evaluate, consider treatment, and/or render your opinion regarding this patient's ocular condition. I look forward to receiving your opinion and will resume general eye care following your consultation.

☐ **TRANSFER OF CARE:** Please evaluate, treat and assume further care for this patient.

Referring Doctor's Signature: _____ Referring Doctor: _____

Office Phone Number: _____ Office Fax: _____

Please fax all consult requests to the office where you would like the patient to be evaluated at. Thank you.