Charm CITY EYE CARE

CONSULTATION REQUEST

6418 Reisterstown Rd, Baltimore, MD 21215
Phone: 410-318-8855 Fax: 410-764-3229
www.CharmCityEyeCare.com

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____ Appointment Date & Time: _____

Patient Referred To: _____ Reason for Consultation: _____

PATIENT HISTORY

- ☐ Decrease in BCVA
- ☐ Cataracts
- ☐ Chalazion
- ☐ Congenital Eye Disorder
- ☐ Conjunctivitis / Red Eye
- ☐ Corneal Abrasion / Ulcer
- ☐ Cosmetic
- ☐ Dematochalasis
- ☐ Diabetic Exam
- ☐ Diabetic Retinopathy
- ☐ Dry Eye
- ☐ Epiphora
- ☐ Eye Pain / Redness
- ☐ Eyelid Lesions
- ☐ Flashes / Floaters
- ☐ Foreign Body
- ☐ Glaucoma
- ☐ HIV Eval
- ☐ Keratoconus
- ☐ Macular Degeneration
- ☐ Macular Disease
- ☐ Plaquenil eval
- ☐ Pterygium
- ☐ Ptosis
- ☐ Refractive Surgery / Lasik / PRK
- ☐ Retinal Hemorrage
- ☐ Retinal Vein Occlusion
- ☐ Trauma
- ☐ Uveitis / Iritis
- ☐ Other: _____

EXAMINATION RESULTS

Refraction OD: _____ CC/SC OD: _____
OS: _____ OS: _____

IOP OD: _____ OS: _____ Time: _____

COMMENTS: _____

IF PATIENT IS REFERRED FOR CATARACT SURGERY

☐ I agree to provide post-operative care for this patient following cataract surgery and the *Request for Cataract Co-Management Form* has been completed and signed by both my patient and me, the referring doctor.

REFERRING PHYSICIAN

Doctor Signature: _____ Printed Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Please send this form via fax in advance of the patient's appointment and ask the patient to bring this form on the day of their appointment. Thank you.