CONSULTATION REQUEST

Date:_____

Shamik Bafna, MD Matthew Willett, MD Michael L. Smit, DO Carla Darak-Bolino, OD Brandi Roman, OD

8135 Market Street,
Boardman, OH 44512
P: (330)758-0900 | F: (330)758-2790

Patient Name: _____ **Dob:** _____

Home Phone: _____ **Cell Phone:** _____

☐ Cataract
☐ PCO/YAG Evaluation
☐ Narrow Angles/LPI
☐ SLT
☐ Glaucoma Evaluation
☐ Dry Eye
☐ Red Eye
☐ Flashes/Floaters
☐ Visual Field Defect
☐ Reduced Vision/Visual Field Defect
☐ Diplopia
☐ Scleral Lens Fitting
☐ 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 ocularcondition. 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: _____ Office Location: _____

Address: _____ Office Phone Number: _____

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