Primary Eye Care Provider: ____________________
Location: ____________________
Phone/FAX: ____________________
Contact: ____________________

Asheville eye Associates

CONSULTATION REQUEST

Patient: ____________________ Age: ___ Date of Birth: ___________ Date Referred: _______

Address: ____________________ Telephone: ____________________

City/State/Zip: ____________________

Chief Complaint: ____________________

____

Pertinent Refractive & Ocular History: ____________________

Meds/Dosages: ____________________ Allergies/Dosages: ____________________

Va ________ Pinhole ______ J ______ Ta ______ mm Hg

sc cc ________ ______ ______ ______ mm Hg

@ ______ am pm

W ____________________ Add: ______ M ____________________ 20/ ______ Add: ______

____________________ Add: ______ ____________________ 20/ ______ Add: ______

Exam:

	WNL	Other	Comments:
Pupils:	❑	❑	
Lids/Lashes	❑	❑	
Conjunctiva	❑	❑	
Cornea	❑	❑	
Iris	❑	❑	
A/C	❑	❑	
Lenses	❑	❑	
Fundus	❑	❑	

Assessment/Comments: ____________________

Recommendation of Consultation for:

- ❑ Cataract
- ❑ Retina
- ❑ Plastic
- ❑ YAG Laser
- ❑ Right Eye
- ❑ Left Eye
- ❑ Pediatric/Neuro
- ❑ Multi-focal Lens
- ❑ Glaucoma

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