Consultation Request

ClearView SURGERY CENTER

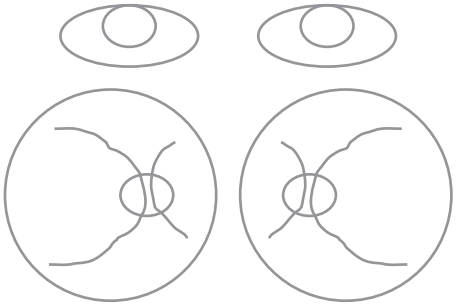
Commitment.
Community.
ClearView.

Patient Name & DOB _____ Referral Date _____

Patient Phone Number _____ Insurance Company _____

Referral for (please choose one): ○ **OU** / ○ **OD** / ○ **OS**

- ☐ LASIK or ASA consultation
- ☐ ICL consultation (> -3.50 sph, <1.00D cyl)
- ☐ Cataract evaluation *(please circle all that apply)*
  - ○ Y / ○ N: patient has >1.00 of corneal cylinder & may be interested in the Toric IOL
  - ○ Y / ○ N: patient is interested in learning more about multifocal IOLs
  - ○ Y / ○ N: history of prior refractive surgery surgery, please specify: ☐ LASIK ☐ PRK ☐ RK ☐ Other: _____
  - ○ Y / ○ N: history of monovision
  - ○ Y / ○ N: patient has been treated for mild to moderate POAG (iStent candidate)
- ☐ Blepharoplasty evaluation
- ☐ Ectropion / entropion / skin lesion
- ☐ YAG capsulotomy
- ☐ Retinal or glaucoma evaluation
- ☐ Diagnostic testing:
- ☐ Other:



Pertinent History

- ☐ Painless, progressive vision decline that's interfering with daily activities
- ☐ Or:

VA	SC	CC	PH
OD			
OS			

MRx	SPH	CYL	AXIS
OD			
OS			

Exam Findings & Concerns:

Other Ocular Pathology

- ☐ Amblyopia
- ☐ ARMD
- ☐ PRVO/CRVO history
- ☐ Diabetic retinopathy
- ☐ Glaucoma (*Meds: _____)
- ☐ Herpetic history
- ☐ Iritis / uveitis history
- ☐ Ocular Trauma:_____
- ☐ Pseudoexfoliation syndrome
- ☐ Strabismus

Scheduling

- ☐ Patient is already scheduled for an appointment with ClearView Eye Clinic doctor on: _____
- ☐ Please call patient to schedule an appointment
- ☐ Please refer to attached medical records for additional information

Fax: 208.883.6557
Phone: 1.866.770.2020

_____
Referring Doctor

ClearView Eye Clinic
CVeyes.com

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