Cornea Service Consult Request

Patient Name: Date of Last Exam:

Date of Birth: Patient Phone:

Referring Doctor:

I would like Devers Eye Institute to call this patient to schedule a consultation

The patient has an appointment with you scheduled on:

Reason for consultation:

Ocular and pertinent systemic history:

Relevant Exam Findings: See attached exam note

Refraction: OD: 20/

OS: 20/

Slit Lamp:

Fundus:

Diagnosis:

Requested Care:

If requested care is cataract:

Prior refractive surgery or corneal disease:

Desired refractive outcome (if discussed): OD: OS:

Preferred type of IOL: Single focus Single focus toric Presbyopic

If co-management is desired, I would like to see my patient: POD 1 POW 1

Report Faxed to Devers Eye Institute Signature:

Devers Eye Institute
Mark Terry, MD / Mike Straiko, MD / P. James Sanchez, MD

Direct Referral Line: (503)413-6540
Front Desk Phone: (503)413-8202
Fax: (503)413-6937