541.343.5000
Fax 541.344.9478
1.888.687.2442
www.pcvi.com

# CLEARVISION
CLEARVISION EYE INSTITUTE

1125 Darlene Lane
Eugene, OR 97401
P.O. Box 10888
Eugene, OR 97440

Name of Patient: ______________________

Date of Birth: __________ Phone: __________

Insurance (primary): ______________________

Insurance (secondary): ______________________

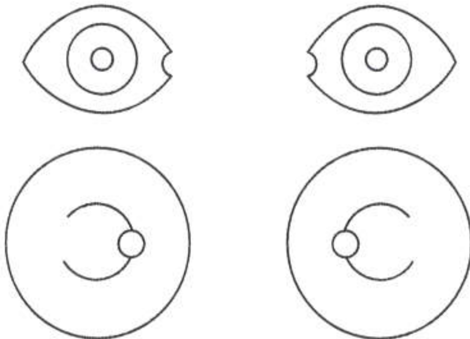
☐ Right Eye ☐ Left Eye

**Vision**

sc / sc /

cc / cc /

**Exam: (Please indicate location of pathology)**



Date of Request: ______________________

Primary Physician: ______________________

Physician Phone: ______________________

**Request For:**

**Anterior Segment:**

- ☐ LASIK Referral
- ☐ Cataract Evaluation
- ☐ Glaucoma
- ☐ Cornea
- ☐ Lids

**Diagnostic Testing:**

- ☐ Fluorescein/Photos only
- ☐ Fluorescein/Photos w/report
- ☐ Nerve Fiber Layer (glaucoma)
- ☐ Visual Field Tests
- ☐ Cornea Topography
- ☐ Cornea Endothelial Cell Count

**Retina:**

- ☐ Diabetes Retinopathy
- ☐ Macular Edema
- ☐ Retinal Detachment
- ☐ Macular Degeneration

**I would like to specifically request an evaluation by:**

- ☐ Scott A. Cherne MD
- ☐ John J. DeGuire MD
- ☐ Omer Gal MD
- ☐ Retina
- ☐ No preference

**Type of request :**

- ☐ Consultation
- ☐ Consult with potential treatment as needed
- ☐ Where appropriate and with the patient's consent, I would like to comanage this patients pre and post operative care.
- ☐ No comanagement - Upon completion of post-operative care, please refer this patient back to our practice
- ☐ Please assume responsibility for this patient's eye care.

Comments/Notes ______________________

______________________

______________________

**Please call our office at 541-343-5000 while patient is present so we may schedule appropriately**

I would like to receive a consultative report by: ☐ Letter ☐ Fax ☐ Phone ☐ E-Mail (Num/Addr) __________

______________________ ______________________

Referring Doctor - **PLEASE PRINT** Doctor Signature

Upon completion, please fax this form to Pacific ClearVision at 541-344-9478