Tel: 541.343.5000
Fax: 541.344.9478
1.888.687.2447
www.pcvi.com

Pacific ClearVision INSTITUTE

1125 Darlene Lane
Eugene, OR 97401
PO Box 10888
Eugene, OR 97440

Name of Patient: _____ Date of Request: _____

Date of Birth: _____ Patient Phone: _____ Primary Physician: _____

Insurance (primary): _____ Physician Phone: _____

Insurance (secondary): _____

❑ Right eye ❑ Left Eye ❑Both eyes

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
❑ Corneal Topography
❑ Corneal Endothelial Cell Count

Vision

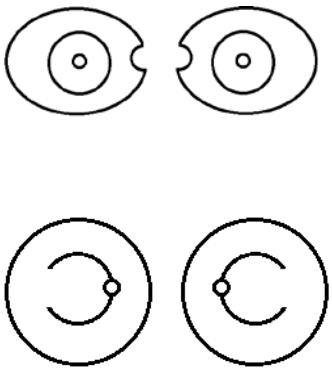
sc / sc /

cc / cc /

I would like to specifically request an evaluation by:

❑ Bala Ambati, MD
❑ Omer Gal, MD
❑ Scott A Cherne, MD
❑ No preference

Exam: (Please indicate location of pathology)



Type of Request:

❑ Consultation
❑ Consult with potential treatment as needed
❑Where appropriate, and with the patient's consent, I would like to co-manage this patient's pre and post-operative care.
❑ No co-management – 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 fax form to our office at 541.344.9478

I would like to receive a consultative report by ❑ Letter ❑ Fax ❑ Phone ❑ Email (num/addr) _____

_____ _____

Referring Doctor – **PLEASE PRINT** Doctor Signature

Upon completion, please fax this form to Pacific ClearVision at 541.344.9478