Tel: 541-343-5000

Fax: 541-344-9478

1125 Darlene Lane

Eugene, OR 97401

www.pcvi.com

Name of Patient: ____

Birthdate: _____________ Patient Phone: ___________________

Insurance (primary): _____________________________________

Insurance (secondary): ______________________________

Date of Request: ____________________________

Primary Physician: ___________________________

Physician Phone: ____________________________

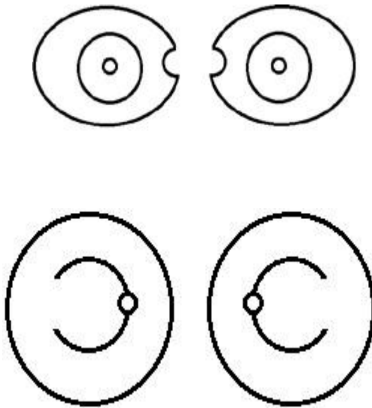
□ Right eye   □ Left eye   □ Both eyes

Vision

sc / cc /

sc / cc /

Exam: (Please indicate location of pathology)



Request For:

Anterior Segment:

- □ LASIK referral
- □ Cataract evaluation
- □ Cataract/ MIGS
- □ Glaucoma
- □ Cornea
- □ Lids
- □ Botox

Diagnostic Testing:

- □ Fundus photos
- □ Nerve fiber layer (glaucoma)
- □ Visual field tests
- □ Corneal Topography
- □ Corneal Endothelial Cell Count
- □ Electroretinography

Type of Request:

- □ Consultation
- □ Consult with potential treatment as needed
- □ Where appropriate, and with the patient's consent, I would like to comanage 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:____

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Referring Doctor - **PLEASE PRINT**

Please fax form to Pacific ClearVision at **541-344-9478**