Tel: 541-343-5000
Fax: 541-344-9478

www.pcvi.com

360 S Garden Way, Suite 25
Eugene, OR 97401

Name of Patient: ______________________________

Birthdate: ______________ Patient Phone: ______________

Insurance (primary): ______________________________

Insurance (secondary): ______________________________

Date of Request: ______________________

Primary Physician: ______________________

Physician Phone: ______________________

Request For:

□ Right eye □ Left eye □ Both eyes

Vision

sc / cc /

sc / cc /

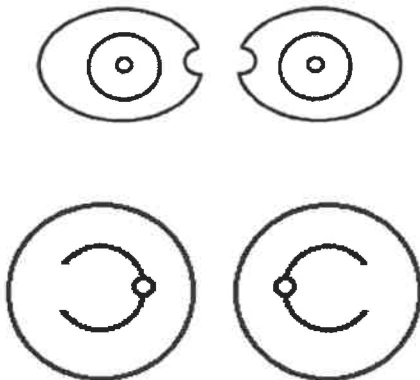
Anterior Segment:

□ 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

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 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**