Consult Request Form

Date : _____/_____/_____

Patient : _____ **DOB :** _____

Phone : _____ **Date of Appointment :** _____

Type of service requested :

__Emergency
__Urgent (3-4 days)
__Routine

__Cataract Evaluation
__YAG PC Evaluation
__Glaucoma Evaluation
__Strabismus
__Diplopia
__Scleral Lens
__Retina - Wet AMD
__Retina - Dry AMD
__Retina _____
__Thyroid Eye Disease
__Ptosis
__Eye lid malposition
__Reconstruction
_____
_____
_____

Visual Acuity :

OD 20/_____ OS 20/_____

Lensometry :

OD:_____20/

OS:_____20/

Refraction :

OD:_____20/

OS:_____20/

Tonometry :

OD : _____ OS : _____

All glaucoma related consults : Please include dates and copy of last HVF, OCT and any other pertinent testing.

Date of last HVF : _____

Date of last OCT : _____

Offices : Phone 330-746-7691 Fax : 330-884-6558

1075 W Western Reserve Rd
Poland, OH 44514

10 Dutton Drive
Youngstown, OH 44502

4060 North River Rd NE
Warren, OH 44484

2670 S Raccoon Rd
Austintown, Ohio 44515

Physician Requested :

__Any Physician
__Oculoplastics
__John Aey, M.D.
__Sergul Erzurum, M.D.
__Zafar Sheik, M.D
__Lyn Yakubov, M.D.
__Sarah Smith, M.D.
__Keith Wilson, M.D.
__Guy Barrett, O.D.
__Thomas Grischow, O.D.
__Nicholas Lawrence, O.D.
__Taylor Richards, O.D.
__Chad Shultz, O.D.
__Kirsten Madick, O.D.

Pertinent Information :

_____
_____
_____
_____
_____
_____
_____
_____
_____

Requesting Doctor : _____
(Please print name)

Office Phone Number : _____

Office Location : _____

Please fax all consult requests along with last chart note to 330-884-6558 prior to patients scheduled appointments, visit will not be scheduled until chart notes received.