OPHTHALMOLOGY CONSULTATION REPORT

Patient Name: _____ To: Doctor _____

ID#: _____ IPA/MG: _____

Date of Birth: _____ Date of Exam: _____

The above named patient was seen in our office as: ❑ New Patient ❑ Established Patient

For: ❑ Routine Eye Exam
❑ Retinal Exam (i.e., Diabetic eye exam)
❑ Glaucoma
❑ Visual Disturbance:_____

❑ Other:_____

Findings/Diagnosis:

❑ Normal Exam ❑ Visual Acuity: RT_____ LT_____

❑ Cataract
❑ Conjunctivitis
❑ Diabetic Retinopathy, background
❑ Diabetic Retinopathy, proliferative
❑ Eyelid disorder
❑ Foreign Body
❑ Glaucoma
❑ Iritis
❑ Keratitis
❑ Lacrimal disorder
❑ Macular degeneration
❑ Optic nerve disorder
❑ Orbit disorder
❑ Retinal detachment
❑ Retinal hemorrhage
❑ Strabismus
❑ Vitreous hemorrhage

❑ Other Dx or Additional information: _____

_____

Follow-up Plan:

❑ Return in _____ weeks
❑ Return in _____ months
❑ Return in one year
❑ Fluorescein Angiogram
❑ Laser treatment
❑ Refraction
❑ Visual Field Exam

❑ Medication prescribed:_____

❑ Surgery recommended:_____

❑ Other:_____

_____

_____ _____ _____

(Physician Signature) (Print Name) (Date)