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CONSULTATION REPORT

Patient Name: _____ Date of Visit: _____

D.O.B.: _____ Patient Phone: _____ Medical Insurance: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Examining Doctor: _____

EXAM FINDINGS:

- ☐ Amblyopia H53.009
- ☐ Astigmatism H52.223
- ☐ Blepharitis H01.009
- ☐ Cataracts. H26.9
- ☐ Conjunctivitis H10.33
- ☐ Corneal Arcus H18.419
- ☐ Diabetes Mellitus with Diabetic Retinopathy E11.31
- ☐ Diabetes Mellitus with Diabetic Retinopathy & Macular Edema E11.311
- ☐ Diabetes Mellitus without Ocular Complications: No Diabetic Retinopathy E11.9
- ☐ Dry Eye Syndrome H04.129
- ☐ Glaucoma ☐ Yes H40.9 ☐ No. Z13.5
- ☐ Glaucoma Suspect H40.009
- ☐ Hyperopia H52.03
- ☐ Hypertensive Retinopathy H35.039
- ☐ Macular Degeneration H35.30
- ☐ Myopia H52.13
- ☐ Pinguecula H11.159
- ☐ Presbyopia H52.4
- ☐ Pseudophakia Z96.1
- ☐ Pterygium H11.009
- ☐ Ptosis H02.409
- ☐ Retinal Detachment H33.0
- ☐ Retinal Hole / Tear H33.329
- ☐ Vitreous Detachment/Floaters H43.81
- ☐ Dilated Diabetic Exam 2022F
- ☐ Patient refused dilation
- ☐ _____

☐ Other _____

PLAN:

☐ Monitor Only ☐ New Spectacle/Contact lens prescription given

☐ Refer patient to ☐ Ophthalmology ☐ Retinal Specialist ☐ Primary Care Dr.

☐ Reason / DX _____

☐ Other _____

Visual Acuity: 20/_____ OD

20/_____ OS

IOP OD_____ mmHg@_____ AM / PM

OS _____ mmHg

☐ Referral to be administered by PCP ☐ Patient given referral from our office ☐ Patient given a copy of this report

FOLLOW UP IN OUR OFFICE:

_____Day(s) _____Week(s)_____Month(s) ☐ 1 Year for

☐ Annual Exam ☐ Dilation ☐ Retinal Photos ☐ Refraction ☐ Intraocular Pressure Check ☐ Visual Field ☐ OCT ☐ Other _____

I authorize the release of any necessary medical information to my primary care physician, referring physician, or specialist.

_____ _____
Patient or Legal Guardian Signature *Date*

_____ _____
Doctor's Signature *Date*