CONSULT REQUEST

SightLine Ophthalmic Associates
Phone 724-933-5588 • Fax 724-933-6051

PATIENT NAME ___________________________________

DATE OF BIRTH __________________________________

REFERRING DOCTOR _______________________________

DATE OF EXAM ___________________________________

☐ I have scheduled an appointment for this patient on:

____

☐ I would like Sightline to call this patient to schedule:

PATIENT PHONE __________________________

EYE HEALTH HISTORY:
(And other pertinent health Hx)

CURRENT OCULAR SYMPTOMS:

RELEVANT CLINICAL FINDINGS:

IOP: R ___________

L ___________

CURRENT REFRACTION:

R ____ 20/_______

L ____ 20/_______

SLIT LAMP:

FUNDUS:

DIAGNOSIS:

REQUESTED CARE:

______ Report Faxed to SightLine

Signature ____