KERATOCONUS/CORNEAL CROSS Sightline Ophthalmic Associates

LINKING CONSULT REQUEST Phone 724-933-5588 • Fax 724-933-6051 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ I have scheduled an appointment for this patient on:

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ I would like Sightline to call this patient to schedule:

DATE OF EXAM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR REFERRAL:

CURRENT OCULAR SYMPTOMS:

EYE HEALTH HISTORY (And other pertinent health Hx):

[ ]  Pt already diagnosed with keratoconus Date of diagnosis:\_\_\_\_\_\_\_\_\_\_

[ ]  Pt suspect of having keratoconus

[ ]  Pt had laser vision correction Date of laser surgery:\_\_\_\_\_\_\_\_\_\_

Pt wears contact lenses: [ ]  soft [ ]  RGP [ ]  Scleral [ ]  Spectacle or no correction

CURRENT REFRACTION:

OD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20/\_\_\_\_\_\_\_

OS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20/\_\_\_\_\_\_\_

PREVIOUS REFRACTION DATE: \_\_\_\_\_\_\_\_\_\_

OD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20/\_\_\_\_\_\_\_

OS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20/\_\_\_\_\_\_\_

PERTINENT SLIT LAMP FINDINGS:

[ ]  Scarring

[ ]  Striae

 PERTINENT FUNDUS FINDINGS:

DIAGNOSIS:

REQUESTED CARE: [ ]  EVALUATION/TOPOGRAPHY ONLY

 [ ]  EVALUATION AND CROSS LINKING IF INDICATED

 [ ]  TOPOGRAPHY ONLY

IF PATIENT REQUIRES CONTACT LENSES, DO YOU FIT RGP AND SCLERAL CONTACTS? [ ]  YES [ ]  NO

\_\_\_\_\_\_ Report Faxed to Sightline Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_