MEDICAL CONSULT REQUEST

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

PATIENT NAME ______________________________________ PHONE # ____________________________

DATE OF BIRTH ____________________________________ ☐ I would like Sightline to call this patient to schedule.

REFERRING DOCTOR _______________________________ DATE OF LAST EXAM ______________________

REASON FOR REFERRAL: ☐ PCO ☐ EBMD/NODULES ☐ FUCHS DYSTROPHY/CORNEAL EDEMA
☐ KERATOCONUS ☐ NARROW ANGLES ☐ CORNEAL ULCER ☐ GLAUCOMA ☐ CONJ CHALASIS

OTHER:____

PERTINANT OCULAR HISTORY:

CURRENT EYE DROPS/OCULAR MEDICATIONS:

CURRENT REFRACTION & BCVA:

R ______________________________________ 20: /_______

L ______________________________________ 20/_______

CUP TO DISC: OD: ___________ GLAUCOMA STAGE (if applicable): IOP: OD_________
(If applicable)
OS: ___________ ☐ Mild ☐ Moderate ☐ Severe OS__________________

REQUESTED PROCEDURE: ☐ YAG CAPSULOTOMY ☐ YAG PI ☐ SLT ☐ OTHER ________________

REQUESTED TESTING: ☐ TOPOGRAPHY ☐ OCT ☐ HVF ☐ OTHER: _______________________

PLEASE INDICATE WHICH EYE SHOULD BE TREATED:
☐ RIGHT EYE ☐ LEFT EYE ☐ BOTH EYES

Specific Requests:____

This patient has chosen to have post operative care at: _____ Sightline _____ Our office

Signature ___________________________________