

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: _____

For Yag Capsulotomy, this patient has chosen to have post operative care at:

_____ **Sightline** _____ **Our office (and we will bill for the post-operative care)**

Signature _____