GENERAL CONSULT REQUEST

Cataract and Eye Consultants
Phone 724-617-2020 • Fax 724-453-4108

PATIENT NAME _____

DATE OF BIRTH _____

REFERRING DOCTOR _____

DATE OF EXAM _____

CEC will call this patient to schedule:

PATIENT PHONE _____

Please send a copy of the current insurance card +photo ID for insurance verification if possible

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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:

_____ date report faxed to CEC

Signature _____