NORTHEAST OHIO EYE SURGEONS

General Consultation Request Date: _____

☐ Lawrence Lohman, M.D., FACS
☐ Marc Jones, M.D., FACS
☐ Kimberly Cingle, M.D.
☐ Matthew Willett, M.D.
☐ Elizabeth Muckley, O.D., FAAO
☐ William Rudy, O.D., FAAO
☐ Katie Greiner, O.D., M.S., FAAO
☐ Katherine Hastings, O.D.
☐ Marcella Pipitone, O.D.

2013 St. Rt. 59
Kent, Oh 44240
330-678-0201
800-255-3671

4277 Allen Road
Stow, Oh 44224
330-928-0201
800-548-1729

The Glaucoma Center
1 Park West Blvd.
Suite 310
Akron, Ohio 44320
330-836-8545

Patient: _____ **DOB:** _____

Home: _____ **Cell:** _____

☐ **NEOES Appointment Date:** _____

☐ **Please have NEOES call patient directly to schedule appointment**

☐ **Cataract Evaluation**	☐ **Glaucoma Evaluation**	☐ **Reduced Vision**
☐ **PCO/YAG Evaluation**	☐ **Red Eye**	☐ **Visual Field Defect**
☐ **Corneal Evaluation**	☐ **Flashes/Floaters**	☐ **Diplopia**
		☐ **Other:** _____

ALL Consultations, please provide refractive error and best corrected vision:
Date of latest Manifest Refraction (MR): _____ ☐ **MR not available**

OD: _____**20/**_____ **CL RX: OD:** _____

OS: _____**20/**_____ **OS:** _____

Any history of Contact Lens Wear?: **Yes** **No**
Multifocal CLs? **Good** **Fair** **Poor** **Never Attempted**
Monovision? **Good** **Fair** **Poor** **Never Attempted**
Best tolerated add: _____ **Near Eye: OD OS**

Glaucoma-related consults: Any past information is helpful including pre-tx IOP, previous glaucoma meds, cup-to-disc ratios, and if available, send copy of all THRESHOLD visual fields, pachymetry, and copy of optic nerve/NFL analyzers.

Date: _____/_____ IOP _____/_____ Date: _____/_____ IOP _____/_____ Date: _____/_____ IOP _____/_____
Mo Year Ta, Tp, NCT Mo Year Ta, Tp, NCT Mo Year Ta, Tp, NCT

Pertinent Information:
_____
_____
_____
_____

☐ **Consultation Request**: Please evaluate, consider treatment, and/or render your opinion regarding this patients ocular condition. I look forward to receiving your opinion and will resume general eye care following your consultation.

☐ **Transfer of Care**: Please evaluate, treat and care for this patient.

Requestor's Signature: _____ Requesting Doctor: _____
Address: _____ Office Phone Number: _____

Please fax all consult requests to 330-678-4272 prior to patients scheduled appointment or ask patient to bring this form on the day of the appointment. Thank you

July 2016