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.
- ☐ Elizabeth Esparaz, M.D.

2013 State Rt. 59
Kent, OH 44240
Phone **330-678-0201**
Toll-Free **800-548-1729**
Fax **330-678-4272**

4277 Allen Rd.
Stow, OH 44224
Phone **330-928-0201**
Toll-Free **800-548-1729**
Fax **330-926-0201**

4099 Embassy Pkwy.
Akron, OH 44333
Phone **330-836-8545**
Toll-Free **800-255-3671**
Fax **330-836-8598**

Patient: ______________________________ **DOB:** ________________

Home: ________________________ **Cell:** ________________________

☐ **NEOES Appointment Date:** ____________________

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

- ☐ **Cataract Evaluation**
- ☐ **PCO/YAG Evaluation**
- ☐ **Corneal Evaluation**
- ☐ **Glaucoma Evaluation**
- ☐ **Red Eye**
- ☐ **Flashes/Floaters**
- ☐ **Reduced Vision**
- ☐ **Visual Field Defect**
- ☐ **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: _____/_____ (Mo / Year) IOP _____/_____ (Ta, Tp, NCT) Date: _____/_____ (Mo / Year) IOP _____/_____ (Ta, Tp, NCT) Date: _____/_____ (Mo / Year) IOP _____/_____ (Ta, Tp, NCT)

Pertinent Information:
____
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☐ **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