



General Consultation Request

Date: _____

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|---|--|--|
| <input type="checkbox"/> Lawrence Lohman, M.D. (Akron, Kent, Stow) | <input type="checkbox"/> Katie Greiner, O.D. (Stow) | <input type="checkbox"/> Jennifer S. Vincent, O.D. (Akron, Kent, Wadsworth, Medina) |
| <input type="checkbox"/> Marc Jones, M.D. (Akron, Kent, Stow) | <input type="checkbox"/> Katie Hastings Zajac, O.D. (Akron, Kent, Stow) | <input type="checkbox"/> Samantha R. Zaczyk, O.D. (Akron, Kent) |
| <input type="checkbox"/> Matthew Willett, M.D. (Akron, Stow) | <input type="checkbox"/> Marcella Pipitone, O.D. (Akron, Stow) | <input type="checkbox"/> Amy Fernandez, O.D. (Medina, Wadsworth) |
| <input type="checkbox"/> Myron E. Bodnar M.D. (Wadsworth, Medina) | <input type="checkbox"/> Elizabeth Muckley, O.D. (Akron, Kent, Stow) | <input type="checkbox"/> Sara Prusinski, O.D. (Medina, Wadsworth) |
| <input type="checkbox"/> Elizabeth Esparaz, M.D. (Akron, Kent, Stow) | <input type="checkbox"/> William Rudy, O.D. (Kent, Stow) | |
| <input type="checkbox"/> Thomas S.K. Chi, M.D. (Medina, Wadsworth) | <input type="checkbox"/> David B. Beckett, O.D. (Akron, Kent, Stow) | |

2013 State Rt. 59 Kent, OH 44240 Phone: 330-678-0201 Fax: 330-678-4272	4277 Allen Rd. Stow, OH 44224 Phone: 330-928-0201 Fax: 330-926-0201	4099 Embassy Pkwy. Akron, OH 44333 Phone: 330-836-8545 Fax: 330-836-8598	3583 Reserve Commons Dr. Medina, OH 44256 Phone: 330-722-8300 Fax: 330-725-0445	One Park Centre Dr. Suite 106 Wadsworth, Ohio 44281 Phone: 330- 334-1300 Fax: 330-725-0445
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Patient: _____ **DOB:** _____
Home: _____ **Cell:** _____

- NEOES Appointment Date:** _____
 Please have NEOES call patient directly to schedule appointment

- | | | |
|---|--|--|
| <input type="checkbox"/> Cataract Evaluation | <input type="checkbox"/> Flashes / Floaters | <input type="checkbox"/> Vision Therapy |
| <input type="checkbox"/> PCO/YAG Evaluation | <input type="checkbox"/> Reduced Vision | <input type="checkbox"/> TESTING ONLY/NO EXAM |
| <input type="checkbox"/> Corneal Evaluation | <input type="checkbox"/> Visual Field Defect | (list test): _____ |
| <input type="checkbox"/> Glaucoma Evaluation | <input type="checkbox"/> Diplopia | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Red Eye | <input type="checkbox"/> Scleral Lens Fitting | _____ |

ALL Consultations, please provide refractive error and best corrected vision:
Date of latest Manifest Refraction (MR): _____
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.

Referring Doctor's Signature: _____ Referring Doctor: _____
 Address: _____ Office Phone Number: _____

Please fax all consult requests for Stow, Kent, or Akron to 330-678-4272 and Medina or Wadsworth to 330-725-0445 prior to the patients scheduled appointment or ask the patient to bring this form on the day of the appointment. Thank you.