NORTHEAST OHIO EYE SURGEONS

General Consultation Request

Date: _____

- ☐ **Lawrence Lohman, M.D.** (Akron, Kent, Stow)
- ☐ **Marc Jones, M.D.** (Akron, Kent, Stow)
- ☐ **Matthew Willett, M.D.** (Akron, Stow)
- ☐ **Thomas S.K. Chi, M.D** (Medina, Wadsworth)
- ☐ **Elizabeth Esparaz, M.D.** (Akron, Kent, Stow)
- ☐ **Rachel Davis, M.D.** (Akron, Kent, Stow, and Medina)
- ☐ **Myron E. Bodnar M.D** (Wadsworth, Medina)
- ☐ **Katie Greiner, O.D.** (Stow)
- ☐ **Katie Hastings Zajac, O.D.** (Akron, Kent, Stow)
- ☐ **Marcella Pipitone, O.D.** (Akron, Stow)
- ☐ **Elizabeth Muckley, O.D.** (Akron, Kent, Stow)
- ☐ **William Rudy, O.D.** (Kent, Stow)
- ☐ **Emma Reynolds, O.D.** (Akron, Kent, Stow)
- ☐ **David B. Beckett, O.D.** (Akron, Kent, Stow)
- ☐ **Jennifer S. Vincent, O.D.** (Akron, Kent, Wadsworth, Medina)
- ☐ **Samantha R. Zaczyk, O.D.** (Akron, Kent)
- ☐ **Amy Fernandez, O.D.** (Medina, Wadsworth)
- ☐ **Sara Prusinski, O.D.** (Medina, Wadsworth)

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**

Patient: _____ **DOB:** _____

Home #: _____ **Cell #:** _____

☐ **NEOES Appointment Date:** _____

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

- ☐ **Cataract Evaluation**
- ☐ **PCO/YAG Evaluation**
- ☐ **Corneal Evaluation/ Cross-Linking**
- ☐ **Glaucoma Evaluation**
- ☐ **Lid/Oculoplastics**
- ☐ **Red Eye**
- ☐ **Flashes / Floaters**
- ☐ **Reduced Vision**
- ☐ **Visual Field Defect**
- ☐ **Diplopia**
- ☐ **Scleral Lens Fitting**
- ☐ **Vision Therapy**
- ☐ **TESTING ONLY/NO EXAM (list test):** _____
- ☐ **Other:** _____

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: ____/____ (Mo / Year) IOP: ____/____ (Ta, Tp, NCT)

Date: ____/____ (Mo / Year) IOP: ____/____ (Ta, Tp, NCT)

Date: ____/____ (Mo / Year) IOP: ____/____ (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.