ALABAMA EYE
PHYSICIANS & SURGEONS

5937 W Main St.
Dothan, AL 36305
Tel. 334-446-0872
Fax. 334-446-0893
www.Alabama-Eye.com

CONSULTATION REQUEST

Please fax this form to **334-446-0893**

PATIENT NAME	DOB	PATIENT REFERRED TO
DIAGNOSIS		PATIENT PHONE NUMBER
APPOINTMENT DATE	TIME A.M. P.M.	ONSET DATE

I am sending this patient to you for assistance with his/her care. Please evaluate this patient's problem(s) or condition(s):

CATARACT
- ❑ Same day cataract surgery
- ❑ Standard IOL
- ❑ Premium options discussed
- ❑ Astigmatism correction candidate
- ❑ PCO-posterior capsular opacification

GLAUCOMA
- ❑ Narrow angles
- ❑ High IOP
- ❑ Disc cupping
- ❑ Field loss
- ❑ Glaucoma suspect

ANTERIOR SEGMENT
- ❑ Pterygium/Conjunctivitis
- ❑ Dry eye
- ❑ Keratitis
- ❑ Iritis
- ❑ Corneal abrasion/Ulcer
- ❑ Foreign body

PLASTICS
- ❑ Chalazion
- ❑ Eyelid lesion
- ❑ Tearing
- ❑ Orbit
- ❑ Trauma
- ❑ Thyroid-related disease

RETINA
- ❑ Diabetes
- ❑ Flashes/Floaters ARMD (dry/wet)
- ❑ Retinal breaks
- ❑ Plaquenil check
- ❑ Retinal detachment
- ❑ Macular disease

NEURO-OPHTHALMOLOGY
- ❑ Optic nerve edema
- ❑ Cranial nerve 3 palsy
- ❑ Cranial nerve 6 palsy
- ❑ Giant cell arteritis
- ❑ Diplopia

OTHER:

RESULTS OF EXAMINATION

Refraction OD _____ BCVA OD _____

OS _____ OS _____

IOP OD _____ mm Hg OS _____ mm Hg Time _____am/pm

COMMENTS

REFERRING PHYSICIAN

WOULD YOU LIKE TO CO-MANAGE THIS PATIENT? ❑ YES ❑ NO	TELEPHONE	FAX
REFERRING DOCTOR'S NAME (Please Print)		
REFERRING DOCTOR'S SIGNATURE		DATE

Please send this form via fax in advance of the patient's appointment and ask the patient to bring this form on the day of the appointment. Thank you.

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