northcascade
EYE ASSOCIATES
AND SURGERY CENTER

Pre-Op Co-Management Exam and Consult Request Form

Patient Name: ______________________________DOB: _______________ Date: ____________________

Patient phone: Home______________________ Work: ___________________Cell: ___________________

I am sending this patient to you for assistance with his/her care. Please evaluate this patient's problem(s) or condition(s) *Reason for Consultation:* _______________________________________ and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient and will resume general care following your consultation.

Co Managing PECP: ________________________Phone: ______________Fax: ______________NPI#_______________

Is Co Managing PECP contracted with patient's **medical** insurance? Yes No Patient's Medical Insurance Company:_____________

Office Contact: ______________________________________ E-Mail Address: __________________________________

Clinical Information:

Ocular History: ____

Examination: VAsc OD: ______________ VAcc OD: ______________ Pupils (dim light): ______________

OS: ______________ OS: ______________ Fields: _________ EOM: ________

Near Vision: OD: ______________ OS: ______________

Keratometry OD: _________________________________ OS: _____________________________

Manifest Refraction OD: ____20/______________

OS: ____20/______________

IOP: (Goldman/Non Con/Other) OD: _______________________ OS: __________________________________

Slit Lamp Exam:

OD: ____

OS: ____

Dilated Fundus Exam:

OD: ____

OS: ____

Type of CLs: __________________ Time out of CLs ________________

Activities of daily living are impaired because of decreased vision.

Additional Comments: ____

Fax completed form to: 360-424-6954