Consultation Request Form

Urgent ☐
Please call (503) 344-5100

Next Available ☐
Please fax (503) 557-4799

EyeHealth NORTHWEST

Dedicated to preserving a Lifetime of vision

Referring Doctor

Name_____

Phone _____Fax_____

Address_____

Date of Exam_____

Patient Information (Please complete all fields)

Name _____

Phone _____

Address _____

Date of Birth _____

Patient Insurance Information_____

Reason for Consultation _____

Clinical Findings	**OD**	**OS**
Best Corrected VA	20/_____	20/_____
Refraction	_____ - _____ x _____	_____ - _____ x _____
IOP	_____mmHg	_____mmHg

Relevant exam findings:_____

Cataract Co-manage ☐

South offices:

- ◯ Lake Oswego
- ◯ Milwaukie
- ◯ Newberg
- ◯ Oregon City
- ◯ Sunnyside
- ◯ Wilsonville

East Offices:

- ◯ Glisan
- ◯ Gresham
- ◯ Providence
- ◯ Southeast

West Offices:

- ◯ Aloha
- ◯ Northwest
- ◯ Peterkort
- ◯ St Vincent
- ◯ Tigard

Requested Provider_____

Retina Specialists

◯ Christopher Aderman, MD ◯ Brian Chan-Kai, MD ◯ Joseph Simonette, MD ◯ Elizabeth Verner-Cole, MD ◯ Jonathan Yoken, MD

Plan

◯ I have scheduled this patient to be seen at EHNW on (date) / /

◯ I would like EHNW to contact this patient to schedule an appointment