

Consultation Request Form



Dedicated to preserving a
Lifetime of vision

Urgent ☐

Please call (503) 344-5100

Next Available ☐

Please fax (503) 557-4799

Co-Manage ☐

Retina ☐

Pediatric/Strabismus ☐

Oculoplastics ☐

Other ☐

Referring Doctor

Name _____

Phone _____ Fax _____

Address _____

Date of Exam _____

Patient Insurance Information _____

Patient Information (Please complete all fields)

Name _____

Phone _____

Address _____

Date of Birth _____

Reason for Consultation

Clinical Findings

OD

Best Corrected VA 20/_____

Refraction _____ - _____ X _____

IOP _____ mmHg

OS

20/_____

_____ - _____ X _____

_____ mmHg

Relevant exam findings:

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 _____

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