General Consultation Request

Date: ____________________

- [ ] Laurence J. Karns, MD
- [ ] Jerry I. Macher, MD
- [ ] Paul W. Turgeon, MD
- [ ] Michael L. Smit, DO
- [ ] Rachel Davis, MD
- [ ] Philip Dickey, OD

Patient: ____________________ DOB: ____________________

Home #: ____________________ Cell #: ____________________

- [ ] NEOES Appointment Date: ____________________
- [ ] Please have NEOES call patient directly to schedule appointment

- [ ] Cataract Evaluation
- [ ] PCO/YAG Evaluation
- [ ] LASIK Evaluation
- [ ] Corneal Evaluation/Cross-Linking
- [ ] Glaucoma Evaluation
- [ ] Lid/Oculoplastics
- [ ] Retina
- [ ] Red Eye
- [ ] Flashers/Floaters
- [ ] Reduced Vision/Visual Field Defect
- [ ] Diplopia
- [ ] Scleral Lens Fitting
- [ ] 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 patient's ocular condition. I look forward to receiving your opinion and will resume general eye care following consultation.
- [ ] **Transfer Care:** Please evaluate, treat and care for this patient.

Referring Doctor's Signature: ____________________ Referring Doctor: ____________________

Address: ____________________ Office Phone Number: ____________________

Please fax all consult requests prior to patient's scheduled appointment. See office fax numbers on reverse side of this form.

NORTHEAST OHIO
EYE SURGEONS

- [ ] **Rachel Davis, MD** (Stow, Akron)
- [ ] **Laurence J. Kerns, MD** (Canton, North Canton)
- [ ] **Jerry I. Macher, MD** (North Canton)
- [ ] **Paul W. Turgeon, MD** (Canton, North Canton)
- [ ] **Michael L. Smit, DO** (Canton, North Canton)
- [ ] **Philip J. Dickey, OD** (Canton, North Canton)

Offices

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Fax: 330-966-8333

DOWNTOWN CANTON

800 McKinley Ave. NW
Canton, Ohio 44720

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AKRON

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Akron, Ohio 44333

phone: 330-836-8545

Fax: 330-836-8598

STOW

4277 Allen Road
Stow, Ohio 44224

phone: 330-928-0201

fax: 330-926-0201

Surgery Center

Institute for Refractive & Intraocular Surgery (**IRIS**)
800 McKinley Ave. NW
Canton, Ohio 44720

phone: 330-639-0046