KERATOCONUS/CORNEAL CROSS Sightline Ophthalmic Associates

LINKING CONSULT REQUEST Phone 724-933-5588 • Fax 724-933-6051 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ I have scheduled an appointment for this patient on:

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ I would like Sightline to call this patient to schedule:

DATE OF EXAM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR REFERRAL:

CURRENT OCULAR SYMPTOMS:

EYE HEALTH HISTORY (And other pertinent health Hx):

Pt already diagnosed with keratoconus Date of diagnosis:\_\_\_\_\_\_\_\_\_\_

Pt suspect of having keratoconus

Pt had laser vision correction Date of laser surgery:\_\_\_\_\_\_\_\_\_\_

Pt wears contact lenses:  soft  RGP  Scleral  Spectacle or no correction

CURRENT REFRACTION:

OD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20/\_\_\_\_\_\_\_

OS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20/\_\_\_\_\_\_\_

PREVIOUS REFRACTION DATE: \_\_\_\_\_\_\_\_\_\_

OD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20/\_\_\_\_\_\_\_

OS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20/\_\_\_\_\_\_\_

PERTINENT SLIT LAMP FINDINGS:

Scarring

Striae

PERTINENT FUNDUS FINDINGS:

DIAGNOSIS:

REQUESTED CARE:  EVALUATION/TOPOGRAPHY ONLY

EVALUATION AND CROSS LINKING IF INDICATED

TOPOGRAPHY ONLY

IF PATIENT REQUIRES CONTACT LENSES, DO YOU FIT RGP AND SCLERAL CONTACTS?  YES  NO

\_\_\_\_\_\_ Report Faxed to Sightline Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_