Eye Management

REPORT OF OPHTHALMIC CONSULTATION

Date of Service (mm/dd/yyyy)	Patient First Name	Patient Last Name
Provider Last Name	Provider First Name	Provider Phone Number
Consulting Ophthalmologist First Name	Consulting Ophthalmologist Last Name	Consulting Ophthalmologist Phone Number

DIAGNOSIS/FINDINGS:

CONJUNCTIVA
_____ 1. Conjunctivitis
_____ 2. Conjunctival Hemorrhage
_____ 3. Dry Eye
_____ 4. Pinguecula
_____ 5. Pterygium

CORNEA
_____ 6. Corneal Abrasion
_____ 7. Corneal Foreign Body
_____ 8. Corneal Ulcer
_____ 9. Keratitis

EYELIDS
_____ 10. Blepharitis
_____ 11. Chalazion
_____ 13. Ectropion
_____ 14. Entropion
_____ 15. Neoplasm, Benign Eyelid
_____ 16. Neoplasm, Malignant Eyelid
_____ 17. Ptosis, Eyelid
_____ 18. Trichiasis, without entropion

GLAUCOMA
_____ 19. Glaucoma, Open Angle Primary
_____ 20. Glaucoma Suspect
_____ 21. Glaucoma, Narrow Angle
_____ 22. Normal Tension

LACRIMAL
_____ 23. Nasolacrimal Duct Obstruction
_____ 24. Dacryocystitis

LENS
_____ 25. Cataract, Primary
_____ 26. Cataract, Secondary

MUSCLES
_____ 27. Esotropia
_____ 28. Strabismus
_____ 29. Amblyopia

NEURO
_____ 30. Bell's Palsy
_____ 31. Nystagmus
_____ 32. Optic Atrophy
_____ 33. Optic Neuropathy

VISUAL
_____ 34. Photophobia
_____ 35. Pseudophakia (IOL)

RETINA
_____ 36. Retinopathy, Diabetic
_____ 37. Retinopathy, Hypertensive
_____ 38. Retinal Tear
_____ 39. Macular Degeneration
_____ 40. Macular Retinal Edema
_____ 41. Retinal Detachment
_____ 42. Retinal Vein Occlusion

VITREOUS
_____ 43. Vitreous Floaters/Opacity
_____ 44. Vitreous Hemorrhage
_____ 45. Vitreous Detachment

Other:

VISUAL ACUITY: 20/_____ (OD) 20/_____ (OS)

☐ NSAID:	☐ Beta Blocker Selective:	☐ Beta Blocker Non Selective:
☐ Parasympathomimetic:	☐ Steroid:	☐ Antibiotic/Steroid:
☐ CAI(carbonic anhydrase inhibitor):	☐ Prostaglandin analogue:	☐ Antibiotic:

☐ Other:

Treatment/Recommendations:

____
Physician Signature

☐ Referred to Optometrist for Vision/Refractive Care

☐ Follow up: ____ Day(s) ____ Week(s) ____ Month(s) ____ Year ____ PRN

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