

Consultation Request Form



Urgent
Please call (503) 344-5100

Next Available
Please fax (503) 557-4799

Dedicated to preserving a
Lifetime of vision

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

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