

# Consultation Request

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_  
Address: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ S.S.#: \_\_\_\_\_  
Insurance Primary: \_\_\_\_\_ ID# \_\_\_\_\_  
Insurance Secondary: \_\_\_\_\_ ID# \_\_\_\_\_

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**Additional Patient Information:**

Contact person: \_\_\_\_\_  
Phone#: \_\_\_\_\_

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**Referral Information:****Referred by:**

Primary Care Physician: \_\_\_\_\_  
Optometrist: \_\_\_\_\_  
Ophthalmologist: \_\_\_\_\_

Current Acuity (BVA): \_\_\_\_\_ Current Glasses RX: \_\_\_\_\_  
OD 20/ \_\_\_\_\_ OD  
OS 20/ \_\_\_\_\_ OS

Diagnosis: OD \_\_\_\_\_  
Stable/Uncertain  
OS \_\_\_\_\_  
Stable/Uncertain

Date of Last Exam: \_\_\_\_\_

I am referring this patient for Low Vision Consultation and Treatment.

Signature of Referring Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

**Please fax any pertinent treatment documentation for patient including visual field.**

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**Appointment Time:** \_\_\_\_\_

William L. Park, OD, LLC • 610 N. Main • Wichita, KS 67203 • 316-440-1690 • Fax 316-440-1695