Referral/ Consultation Form

Referring Doctor:____

Patient Name:_______________________________**DOB:**_____________

Hughes Eye Appt:___________________________**Location:** __________

Reason for Visit:

☐ **Cataract** ☐ **Glaucoma** ☐ **Retina** ☐ **Other:**___________________

Clinical Findings:

Best Corrected

Visual Acuity **OD: 20/**________________**OS: 20/**_____________

Manifest/AR: **OD:**_______________________________________

OS:_______________________________________

Habitual Rx: **OD:**_______________________________________

OS:_______________________________________

Keratometry: **OD:**_________/__________@_______(steep axis)

OS:_________/__________@_______(steep axis)

IOP: **OD:**___________________**OS:**________________

Lens Description: **OD:**___________________**OS:**________________

Fundus Exam: **OD:**_______________________________________

OS:_______________________________________

Additional Findings: ____

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