



Lifetime Eye Care

Consultation Request

TO: Lifetime Eye Care
4765 Village Plaza Loop Suite 100
Eugene, OR 97401
Phone: (541) 342-3100 Fax: (541) 342-6153
www.LifetimeEyeCare.net

DATE _____
PATIENT _____
ADDRESS _____
CITY/STATE/ZIP _____
TELEPHONE _____

I am requesting a consultation for the following reason(s):

- | | |
|---|---|
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Strabismus/Amblyopia |
| <input type="checkbox"/> Eye Strain/Headaches with: | <input type="checkbox"/> Learning Related Visual Problems |
| <input type="checkbox"/> Computer Use | <input type="checkbox"/> Post trauma/Stroke Evaluation |
| <input type="checkbox"/> Reading/TV | <input type="checkbox"/> Accommodative Dysfunction |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Developmental Delays |
| <input type="checkbox"/> Fluctuating Acuity | <input type="checkbox"/> Exophoria/Esophoria/Hyperphoria |
| <input type="checkbox"/> Other _____ | |

RX: OD _____ 20/_____
OS _____ 20/_____
 Glasses Contact Lens

Additional Information: _____

Consultation Request From:

DOCTOR _____
ADDRESS _____
CITY/STATE/ZIP _____
TELEPHONE _____
EMAIL _____

Lifetime Eye Care will recommend that your patient return to your office for glasses/CL needs.
A copy of your patient's most recent examination findings, if available, would be helpful.

Please Fax Directly to Lifetime Eye Care
(541) 342-6153