

# 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](http://www.lifetimeeyecare.net)

PATIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY/STATE/ZIP \_\_\_\_\_  
TELEPHONE \_\_\_\_\_  
DATE \_\_\_\_\_

**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