Capital Eye Consultants, P.C.

3025 HAMAKER COURT, SUITE 101, FAIRFAX, VIRGINIA 22031
(703) 876-9630 • FAX (703) 876-0163

Referred by _____ Patient's Name _____

Address _____ Birth Date _____ Sex: ☐ M ☐ F

_____ Address _____

CITY STATE ZIP

_____

CITY STATE ZIP

Phone ( ) _____

Fax ( ) _____ Phone ( ) _____

I hereby grant permission for Capital Eye Consultants and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc.

Patient's Signature _____ **Date** _____

Reason for Referral: ☐ Cataract Eval. ☐ Glaucoma Eval. ☐ Retinal Eval. ☐ Other _____

Pertinent Symptoms, History _____

RESULTS OF EXAMINATION *(Please include these findings for each patient.)*

Refraction: OD _____ VA OD _____

OS _____ OS _____

Other Pertinent Results of Examination _____ TA: OD _____ mmHg

OS _____ mmHg

Time _____

Services Requested:

Cataract Surgery
- ☐ Post-operative Comanagement
- ☐ Return for Primary Care

Retinal
- ☐ Referral
- ☐ Comanagement
- ☐ Consult Only
- ☐ FFA
- ☐ OCT

Glaucoma
- ☐ Referral
- ☐ Comanagement
- ☐ Consult Only
- ☐ **Visual Field Only**
- ☐ **GDx Only**

Other: _____

Signed by Dr. _____

Please ask all patients to bring their current medications (ocular and systemic) with them to the Office.

CEC Quick Report: _____

☐ Dictated Report to follow ☐ No further Report

Signed by Dr. _____