

MEDICAL RECORD	CONSULTATION SHEET
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REQUEST		
TO: OPTOMETRY CLINIC M, T, W, F 0730-0900 REASON FOR REQUEST <i>(Complaints and findings)</i>	FROM: <i>(Requesting physician or activity)</i> PHYSICAL EXAMS	DATE OF REQUEST

SM WHO ARE 40+ NEEDING IOP AND VISUAL FOR PHYSICAL

PROVISIONAL DIAGNOSIS

PHYSICAL EXAM

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION <input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL	<input checked="" type="checkbox"/> ROUTINE <input type="checkbox"/> 72 HOURS	<input type="checkbox"/> TODAY <input type="checkbox"/> EMERGENCY
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CONSULTATION REPORT					
RECORD REVIEWED	<input type="checkbox"/> YES <input type="checkbox"/> NO	PATIENT EXAMINED	<input type="checkbox"/> YES <input type="checkbox"/> NO	TELEMEDICINE	<input type="checkbox"/> YES <input type="checkbox"/> NO

IOP
R: _____
L: _____

BY NCT/ APPLANTION

VISUAL ACUITY

UNCORRECTED: DISTANT	R: 20/___	CORRECTED: R: 20/___
	L: 20/___	L: 20/___
NEAR	R: 20/___	R: 20/___
	L: 20/___	L: 20/___

(Continue on reverse side)

SIGNATURE AND TITLE		DATE
HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT
RELATION TO SPONSOR	SPONSOR'S NAME <i>(Last, first, middle)</i>	SPONSOR'S ID NUMBER <i>(SSN or Other)</i>
PATIENT'S IDENTIFICATION <small><i>(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)</i></small>	REGISTER NO.	WARD NO.

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Medical Record