theeyestudio
A Vision Wellness Experience

Consultation/Treatment Request Form

Please fax completed form to (503) 219-0024 along with any corresponding chart notes.

Referring Provider

Name _____
Office _____
Phone _____
Fax _____
Date of Exam _____

Patient Information

Name _____
Parent (if minor) _____
DOB _____
Phone _____
Address _____
_____

Insurance Information

Vision Carrier _____ Relationship to Insured _____
Policy _____ Group _____
Medical Carrier _____ Relationship to Insured _____
Policy _____ Group _____

Reason for Consultation _____

Dry Eye Treatment

- ◉ Intense Pulsed Light (IPL)
- ○ Radio Frequency (RF)
- ○ LipiFlow
- ○ TearCare

Specialty Contact Lenses

- ○ Myopia Control
- ○ Orthokeratology
- ○ Scleral Lenses

Specialty Service

- ○ Blephex
- ○ Zest

Clinical Findings

	OD	OS
BCVA	20/ _____	20/ _____
Final Refraction	_____ - _____ x _____	_____ - _____ x _____
IOP	_____ mmHg	_____ mmHg

Requested Provider

- ◉ Tina Tsai, OD
- ○ Lindsey Rosencrans, OD

We are committed to your patients wellness, and value your continued partnership.

339 NW 9th AVE Portland, OR 97209 the-eyestudio.com (503) 219-0023 (503) 219-0024