



OPTOMETRIC CONSULT SERVICES REQUEST FORM

Patient Information:

Patient Name: _____ DOB _____

Nursing Facility: _____

Attending Physician Name (please print): _____

Attending Physician Signature: (please sign below)

Signature *Date*

Please fax this form with a copy of the resident's face sheet/insurance information to: 1-888-294-9652 for services to be scheduled.

- This form must be completed by the nursing facility's staff for all eye care services requested.
- Please check the appropriate boxes in the space below.
- Completion of this form implies that authorization has been given to the nursing facility, by the responsible party, for Solutions for Sight to bill all applicable insurances and receive payments of medical benefits.

Patient's Primary Eye Complaint / Medical Problem:

- Decreasing or blurred vision
- Ocular discomfort Redness Discharge Itching Dryness Excessive tearing Ocular pain

- Rule out condition / progression of:
- Glaucoma
 - Macular Degeneration
 - Cataracts
 - Diabetic Retinopathy
 - Persistent Blepharitis
 - Conjunctivitis
 - Dry Eye
 - Corneal Degeneration
 - Optic Atrophy
 - Other: _____

Eyeglasses are broken / lost and there is no previous eye history on this resident. Please evaluate ocular health to rule out / treat ocular disease and evaluate need for eyeglasses.