NVISION® EYE CENTERS

CONSULT REQUEST FORM

Please fax this form to 888-572-9581 upon completion.

ECP ID#: _____

Preferred Location: Furlong Vision Correction Preferred Surgeon: _____

Consult For: ☐ Laser Vision Correction ☐ Cataract ☐ RLE ☐ Corneal Issue ☐ Dry Eye
☐ Glaucoma ☐ Retina ☐ Other: _____

Please note that not all locations can accommodate all referral types.

Your NVISION® Representative: _____ Today's Date: _____/_____/_____

Patient Name:_____ Age: _____ DOB:_____/_____/_____

Address:_____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email Address:_____ Best To Contact By: ☐ Cell ☐ Email ☐ Work ☐ Home

Additional Information/Comments:_____

_____

CTL History: ☐ Soft ☐ Soft Toric ☐ RGP Number of Years Worn:_____ Monovision Y/N R/L Near Target:_____

MANIFEST REFRACTION OR CURRENT SPECTACLE RX

OD _____ x _____ 20/ _____J_____

OS _____ x _____ 20/ _____J_____

ADD:_____

Ocular Hx: _____

PATIENT INSURANCE INFORMATION

Policy Number:_____ Group Number:_____

*Please attach a copy of front and back of insurance card along with any applicable chart notes.

CO-MANAGING DOCTOR INFORMATION

Referring Doctor's Name: (PLEASE PRINT) _____

Email: _____

Doctor's Phone Number: _____ Doctor's Fax Number: _____

Practice Name/Managing Doctor's Name: (IF DIFFERENT THAN ABOVE) _____

Practice Address: _____

City: _____ State: _____ Zip Code: _____

Comments: _____

_____

____ I desire to co-manage this patient. I understand that co-management of patients is decided on a case-by-case basis and occurs when medically appropriate. When a transfer of care occurs, I will be responsible for my portion of the patient's post-operative care.

▶ DOCTOR'S SIGNATURE: _____ Date: _____/_____/_____