

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO: **EYE CLINIC** FROM **USMC OSO, SALT LAKE CITY, UT** DATE:

REASON FOR REQUEST (*Complaints e4.d findings*) A current cycloplegic eye refraction is required to complete this applicant's physical examination. It must show the uncorrected and corrected visual acuity with a refractive prescription, intraocular tension, heterophoria (ES EX RH LH) And field of vision. If visual acuity uncorrected is worse than 20/30, the Cycloplegic examination is not required, however, please do a manifest refraction only. Please ensure an entry is made that states "DISTANT VISUAL ACUITY CORRETS TO 20/20" in space provided

This consultation is good for one (1) visit only. Further tests require a new consult.

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> TODAY
		<input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL	<input type="checkbox"/> 72 HOURS	<input type="checkbox"/> EMERGENCY

CONSULTATION REPORT

RECORD REVIEWER YES NO PATIENT EXAMINED YES NO

VISUAL ACUITY:

UNCORRECTED: OD 20 / _____ OS 20 / _____ OU 20 / _____
 CORRECTED: OD 20 / _____ OS 20 / _____ OU 20 / _____

CYCLOPLEGIC REFRACTION:

OD SPHERE _____ CYLINDER _____ AXIS _____
 OS SPHERE _____ CYLINDER _____ AXIS _____

MANIFEST REFRACTION:

OD SPHERE _____ CYLINDER _____ AXIS _____
 OS SPHERE _____ CYLINDER _____ AXIS _____

SPLIT LAMP EXAM:

HETEROPHORIA:

ES _____
 EX _____
 RH _____
 LH _____

INTRAOCULAR TENSION: OD _____ OS _____

DISTANT ACUITY CORRECTS TO: OD _____ OS _____ OU _____

(Continue on reverse side)

SIGNATURE _____ DATE _____

PATIENT'S IDENTIFICATION (Last, First, Middle) ORGANIZATION REGISTRATION NO. WARD NO.