



Kathleen M. Kinney, OD, FCOVD

Optometric Physician
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Consultation Request Form

Date: ___/___/___

PATIENT INFORMATION

Name: _____

DOB: _____

Phone: (____) _____

Email: _____

REFERRING DOCTOR

Name: _____

Practice: _____

Phone: (____) _____

Fax: (____) _____

Please contact the patient to schedule a consultation with Dr. Kinney.

The patient is scheduled to be seen by Dr. Kinney on ___/___/___.

Reason for Consultation / Areas of Concern: _____

Patient Ocular / Medical History: _____

Visual Acuity:

Unaided

Aided

OD 20 / _____

20 / _____

OS 20 / _____

20 / _____

Refraction:

OD _____ - _____ x _____ 20 / _____ Prism: _____

OS _____ - _____ x _____ 20 / _____ Prism: _____

Glasses Rx:

OD _____ - _____ x _____ 20 / _____ Prism: _____

OS _____ - _____ x _____ 20 / _____ Prism: _____

Add: _____

Please fax or email to patientcare@drkathleenkinney.com. Thank you!