Family Eye Care of the Carolinas
1902 N. Sandhills Blvd., Ste E
Aberdeen, NC 28315
Michael J. Bartiss, OD, MD, FAAO, FAAP, FACS
Benjamin H. Wacker, OD

910-692-2020
fax 800-308-9356

Adult Strabismus and Diplopia Referral Form

Dear Doctor,

To appropriately schedule your consultation request in a timely manner, **please complete this form and fax with copy of last complete eye exam and patient demographics to our office at 800-308-9356.** Once we receive all documents, we will contact your patient to schedule their appointment. Patients could initially be evaluated by Dr. Wacker in his diplopia clinic; Dr. Bartiss will be available to consult on the findings and will see patient if the patient is a surgical candidate and desires surgical intervention. We will notify you of the appointment date and time by fax. Thank you for your referral.

Today's date: _____ Pt DOB: _____

Pt Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

_ _____ Email: _____

Patient Insurance : _____

Referral for evaluation of : _____ Referring Doctor: _____

Symptoms began: _____

Is there a history of double vision (diplopia)? ❑ No

❑ Yes, specify (❑ Vertical ❑ Horizontal ❑ Diagonal ❑ Torsional)

Previous Treatments (check **ALL** the apply):

❑ Unknown ❑ VT/Orthotics ❑ Fresnel Prism (amount ___, base ___, OD or OS)

❑ No Treatment ❑ Occlusion ❑ Ground Prism (amount ___, base ___, OD or OS)

Last manifest refraction data: ..... OD _____ BCVA _____

RFN date: _____ OS _____ BCVA _____

Last cycloplegic data: (cyclogyl, atropine or _____) OD _____ BCVA _____

RFN date: _____ OS _____ BCVA _____

Last dilated examination (month, year): _____ Any posterior segment disease? NO or YES _____

Does the patient have a history of:

Strabismus surgery	❑ Yes ❑ No	Orthoptics/VT	❑ Yes ❑ No	Dry Eyes	❑ Yes ❑ No
Prism in specs	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	AMD	❑ Yes ❑ No
Head/ocular trauma	❑ Yes ❑ No	Hypertension	❑ Yes ❑ No	CVA	❑ Yes ❑ No
Maculopathy	❑ Yes ❑ No	Cataracts	❑ Yes ❑ No		

If pt has history of CVA, date of last MRI or CT and facility where performed? ❑ Not Applicable ❑ _____

Patient's primary care physician: _____ Patient's neurologist: _____

For FECC use only: ❑ Appt scheduled _____ ❑ Pt Notified _____ Tech: _____

❑ Work-in approved _____ ❑ Overbook approved Doctor_____

Revised 01/07/2020