Family Eye Care of the Carolinas
1902 N. Sandhills Blvd., Ste E
Aberdeen, NC 28315
Michael J. Barliss, 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 it to our office, along with chart notes and demographic information to 800-308-9356.** Once we receive this completed form, we will contact your patient to schedule their appointment. Patients will initially be evaluated and treated by Dr. Wacker in his diplopia clinic; Dr. Barliss 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 cooperation.

Today's date: _____ **Pt DOB:** _____

Pt Name: _____ **Primary Phone:** _____

Address: _____ **Secondary Phone:** _____

_____ **Email:** _____

Patient Insurance: _____ **Member ID:** _____

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** that 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 pigment 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_____