Family Eye Care of the Carolinas
1902 N. Sandhills Blvd., Ste E
Aberdeen, NC 28315
Michael J. Bartiss, OD, MD, FAAO, FAAP, FACS
Keith P. Poindexter, OD 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 to our office at 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. Poindexter and Dr. Wacker in their 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 cooperation.

Today's date: _____ Pt DOB: _____

Pt Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

_ _____ Email: _____

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 pegment 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_____