David A. Clark, D.O.
1 Hayden Bridge Way
Springfield, OR 97477

Phone: 541.868.9430
Fax: 541.868.9450
www.oregonneurology.com

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NEURO-OPHTHALMOLOGY REFERRAL FORM

Patient Name _____ **DOB** _____ **Phone**_____

Reason for referral

- ☐ Diplopia
- ☐ Optic nerve disorder
- ☐ Visual Field Defect
- ☐ Hemifacial spasm/Blepharospasm
- ☐ Anisocoria
- ☐ Papilledema
- ☐ Nystagmus
- ☐ Other_____

Exam findings (or include chart notes with referral form)
VA: OD 20/_____ OS 20/_____

Timeframe for evaluation

- ☐ Next available
- ☐ Within _____ days
- ☐ Urgent: Please have a staff member call 541.868.9430 if requested timeframe is within the next 72 hours

Referring Doctor (please print):_____ **Phone**_____