

OREGON BOARD OF OPTOMETRY

1900 Hines St. SE, Ste. 290

Salem, OR 97302

Phone: (503) 399-0662 Fax: (503) 399-0705

email: board@oregonobo.org

Request for Board's Review of Professional Services

1. Requested by (Name): _____

Address: _____

Street

City

State

Zip

Telephone: _____ Occupation: _____

Home

Work

(If the patient involved is a minor and you are the parent or guardian, place **your** name on the line above and the **patient** information in the spaces below.)

Name: _____ Phone: _____

Address: _____

Street

City

State

Zip

2. Name and address of optometrist who provided the professional services:

Name: _____

Address: _____

Street

City

State

Zip

3. Referred to the Board of Optometry by:

Name: _____

Address: _____

Street

City

State

Zip

4. Reason for seeking the professional services of the optometrist: _____

5. Date of initial examination/office visit relating to this request for review:

6. What optometric care was provided? (Please circle)

A. Prescription lenses (glasses) B. Contact lenses C. Visual training(eye exercise)

D. Low-vision aids E. If none of these were prescribed, what was the outcome of the

examination?_____

7. What advice or instructions were you given regarding the optometric care provided?_____

8. Did you follow those instructions?____ Yes____ No Explain:_____

9. When did you first start having problems with the optometric care provided?_____

10. Explain in detail the specific difficulty you are having with the optometric care provided.

11. Did you return to the Doctor regarding the difficulty you are having? _____
_____ Date _____ Action taken or advise given by Doctor _____

12. Name and address of the optometric physician or medical doctor providing previous visual/eye care:
Name: _____ Date last seen: _____
Address: _____
Street City State Zip

13. Name and address of your personal medical physician:
Name: _____
Address: _____
Street City State Zip

14. Describe your general health at the time of your visual examination: _____

15. Please indicate below any prescription and non-prescription medication you take: _____

16. Please send copies of any correspondence or documentation you wish the Board to review.

TO: OREGON BOARD OF OPTOMETRY

FROM: _____ , Consumer/Patient
(Print or type name)

I authorize the Oregon Board of Optometry or any designated representative of the Board to communicate with any optometrist, physician, or other person who may be able to aid and assist in my request for evaluation of professional services and procure information which may assist the Board in the evaluation. I further authorize any optometrist, physician, or other person to disclose and release all information relating to me which may assist the Board in conducting an evaluation of professional services.

Date: _____ Signature: _____

Name of patient: _____ Daytime phone# _____

Signature of Parent/guardian: _____

Address of Patient: _____

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