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CATARACT CONSULTATION REQUEST

This form is for use by optometrist referring a patient for consultation on cataract(s).

Referring Doctor: _____ Date: _____

Patient Name: _____ Phone: _____

Insurance: _____ Pre-cert: _____

Appointment:

☐ Your office has arranged for the patient to see us on _____ (Date) at _____ (Time).

☐ Our office should call the patient to arrange for an appointment.

Vision:	Uncorrected	Corrected	**Refraction:**
OD	20/_____	20/_____	OD: _____ +/- _____ X _____ = 20/_____
OS	20/_____	20/_____	OS: _____ +/- _____ X _____ = 20/_____

Please select one of the following:

❒ I have completed a comprehensive ophthalmologic examination on this patient. Please do not repeat this evaluation. Please schedule patient directly for preoperative appointment. (Fax over relevant clinical notes)

OR

❒ I would prefer Sugarland Eye & Laser Center to fully evaluate the patient with a comprehensive ophthalmic examination before counseling patient on cataract surgery.

Intraocular Lens Choice
Patient Prefers:
❒ Traditional Monofocal IOL (❒ Monovision)
❒ Toric IOL
❒ Multifocal IOL
❒ Undecided

Postoperative Care
I would like the patient to return to my office
❒ for all postoperative care.
❒ for postoperative care after post-op day # ___
❒ once postoperative course is complete.

❒ Patient is aware of shared billing and additional surgical and co-management costs for multifocal intraocular lens.

PLEASE FAX THIS FORM TO THE NUMBER ABOVE OR GIVE THIS FORM TO THE PATIENT TO BRING TO OUR OFFICE. THANK YOU VERY MUCH!