



CONSULT REQUEST

Phone 724-766-0986 • Fax 724-558-9960

*Please fax a patient information sheet (Face Sheet) or fill out the form below in its entirety.

***Please call 724-766-0986 ext.1 to schedule the patient.** Thank you!

PATIENT NAME _____ PATIENT PHONE _____

ADDRESS _____ DOB _____

INSURANCE INFORMATION _____

CONSULT TYPE: CATARACT OFFICE LASER GLAUCOMA OTHER _____

Referring Doctor's Name _____

NOTES: **MOST RECENT EXAM NOTE ATTACHED**

IF PREFERRED, FILL OUT THE INFORMATION BELOW:

PREVIOUS SURGERY OR
EYE HEALTH PROBLEMS:

OLDEST REFRACTION DATE _____

R _____

L _____

RELEVANT CLINICAL FINDINGS:

CURRENT REFRACTION DATE _____

IOP: R _____

R _____ 20/ _____

L _____

L _____ 20/ _____

SLIT LAMP:

FUNDUS:

DIAGNOSIS:

RECOMMENDATIONS:

PLEASE FILL OUT IF CATARACT CONSULT:

CONTACT LENS WEAR: SOFT ASTIGMATIC GP

*Please have patient remove contact lenses 7 days prior to their appointment if cataract consult.

SUGGESTED REFRACTIVE GOAL: RIGHT: PLANO or _____

LEFT: PLANO or _____

IOL PREFERENCE: candidate for premium refractive options not a candidate

POST-OP: Patient has chosen to have post-operative care delivered at **(PLEASE CHECK CORRECT BOX)**

REFERRING OFFICE

BATCHELET EYE OFFICE