BATCHELET EYE
SURGICAL SOLUTIONS

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 for your patient to be scheduled in the timeliest fashion. *

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 CATARCT 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: ☐ YOUR OFFICE ☐ BATCHELET EYE