Cataract Consultation Request Form

REASON FOR CONSULTATION ❑ OU ❑ OS ❑ OD

❑ Cataract Evaluation ❑ YAG Laser Evaluation

❑ Other: _____

Physician Requested ☐ Dr. Mark Kontos ☐ Dr. Christopher Sturbaum ☐ Dr. Jason Croskrey ☐ Any

REFERRING DOCTOR INFORMATION

Name: _____

Phone: _____

Date of Exam: _____

PATIENT CONTACT INFORMATION

Name: _____

Phone: _____

Date of Birth: _____

INSURANCE INFORMATION ❑ See attached for demographics

Primary Insurance Carrier: _____ Policy: _____

Patient Address: _____

Check any that apply

IOL Preference: ❑ Advanced Technology ❑ Monofocal ❑ Toric ❑ Undetermined
- ❑ *I have counseled the patient on the above selected option*
- ❑ *The patient desires to continue post-op care with my office*
- ❑ *The patient may not be a candidate for preferred lens option (see findings)*

Laser-Assisted: ❑ Recommended for laser-assisted cataract surgery

Glaucoma: ❑ Patient is currently managing a glaucoma condition with medications
- ❑ *Recommended or candidate for iStent*

Contact Lenses: ❑ Soft ❑ Rigid ❑ Scleral
- ❑ *Advised patient to discontinue lens wear for 3 weeks prior to consultation*

CLINICAL FINDINGS

Manifest Refraction OD _____ OS _____

20/_____ 20/_____

Pertinent Findings: _____

_____

Recommendation: _____

_____

❑ I have scheduled this patient to be seen at Empire Eye Physicians on _____

❑ Please call to schedule patient

Fax form and any attached clinical documents back to (509) 928-0784.