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PATIENT CONSULTATION FORM

Referring Doctor _____ **Appointment Date** ____/____/____
Medical Insurance _____ **Policy #** _____
Patient Name _____ **DOB:** ____/____/____
Patient Home Phone _____ **Cell** _____
Address _____ **City** _____ **State** ____ **Zip** _____

Ocular Examination
Complaint or History: _____

V OD _____ 20 / _____ **T** Goldman _____ OD _____ @ _____
 OS _____ 20 / _____ NCT Tonopen _____ OS _____ AM PM
Contact Lens: Yes No **Type:** Soft Gas Perm **K's** _____

Cataract Consultation Findings _____
Effects on Daily Living: Reading Driving Glare Work Hobbies _____
 Evaluate surgical necessity of the cataract(s)
 I feel this patient would benefit visually from cataract surgery.
 Although other conditions restrict correctable vision, I believe that improved vision would improve lifestyle.
 Desired post-operative refractive error (plano if blank): OD _____ OS _____
 With the patient's consent, I wish to participate in Co-management as defined by HCFA for Medicare & Medicare Advantage patients.

Other Consultation Consultation Type: Corneal Glaucoma Retinal Yag Other _____
Location and description of findings and concerns _____

Management: Please evaluate and manage this patient's condition accordingly.
 I prefer sharing the responsibility of the care of this patient's condition.
 I am sending this patient for a second opinion, but will continue to manage the condition.
Signature _____, O.D. **Date:** _____