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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: ____________