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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: ______________