Whitewater EYE CENTERS
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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

Prism: ☐ Yes ☐ No

Contact Lens: ☐ Yes ☐ No Type: ☐ Soft ☐ Gas Perm

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: _____