

Requested/Treating Provider: _____
 No Preference/First Available

Whitewater Eye Center Richmond
 1900 Chester Blvd. • Richmond, IN 47374
 Phone: (765) 962-2020 • Fax: (765) 966-2975

Whitewater Eye Center Greenville
 6050 SR 571 E. • Greenville, OH 45331
 Phone: (937) 547-6050 • Fax: (937) 547-1911

Whitewater Eye Center Connersville
 2045 Virginia Ave. • Connersville, IN 47331
 Phone: (765) 825-6000 • Fax: (765) 825-3075

Whitewater Eye Center Batesville
 1088 IN-229 • Batesville, IN 47006
 Phone: (812) 934-9500 • Fax: (812) 933-1771

Whitewater Eye Center Greensburg
 955 N Michigan Ave., Ste 2 • Greensburg, IN 47240
 Phone: (812) 222-2020 • Fax: (855) 515-0832

Whitewater Eye Center Greenfield
 400 W. Green Meadows Dr., Suite 108 • Greenfield, IN 46140
 Phone: (765) 962-2020 • Fax: (855) 425-4469

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: _____