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☐ **Emilie J. Jennings, O.D.**
☐ **H. B. Harold Lee, M.D.**
☐ **Judy D. Risch, O.D.**
☐ **Kevin T. Scripture, M.D.**

PATIENT CONSULTATION FORM

Referring Doctor _____ Medical Insurance _____

Patient Name _____ DOB: ____/____/____

Appointment Date _____ Address _____

Patient Phone _____ 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 ☐ _____

☐ Discussed LenSx® - Pt. interested in premium lens choices.

☐ 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.

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: _____