WHITEWATER
EYE CENTERS
Ph: (866) 788-0001 • Fx: (765) 966-2975

☐ Eye Center of Richmond
1900 Chester Blvd.• Richmond, IN 47374
Phone: (765) 962-2020
Toll Free: (866) 788-0001
Fax: (765) 966-2975
www.eyecenterofrichmond.com

☐ Eye Center of Greenville
6050 SR 571 E.• Greenville, OH 45331
Phone: (937) 547-6050
Toll Free: (866) 788-0001
Fax: (937) 547-1911
www.eyecenterofgreenville.com

☐ Eye Center of Connersville
2045 Virginia Ave.• Connersville, IN 47331
Phone: (765) 825-6000
Toll Free: (866) 788-0001
Fax: (765) 825-3075
www.eyecenterofconnersville.com

☐ Randolph Eye Center
310 S. Oak St.• Winchester, IN 47394
Phone: (765) 962-2020
Toll Free: (866) 788-0001
Fax: (765) 966-2975
www.eyecenterofrichmond.com

☐ Elise L. Beatty, O.D.
☐ Timothy J. Beatty, O.D.
☐ Michael S. Bloom, M.D.
☐ B. Christopher Hainline, M.D.
☐ Emilie J. Jennings, O.D.
☐ Jessica L. Lambert, O.D.
☐ H. B. Harold Lee, M.D.
☐ Judy D. Risch, O.D.
☐ Kevin T. Scripture, M.D.

PATIENT CONSULTATION FORM

Referring Doctor _____

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 ☐ Neuro ☐ 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: _____