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CATARACT CONSULTATION REQUEST

This form is for use by optometrist referring a patient for consultation on cataract(s). For laser vision correction consultation or any other eye consultation, consider using our Laser Vision Consultation Request form and General Consultation Request form respectively. **Download all forms at www.SugarLandEye.com.**

Referring Doctor: _____ Date: _____

Patient Name: _____ Phone: _____

Insurance: _____ Precert: _____

Appointment:

Your office has arranged for the patient to see us on _____ at _____.

Date

Time

Our office should call the patient to arrange for an appointment.

Vision:	Uncorrected	Corrected	Refraction:
OD	20/____	20/____	OD: _____ +/- _____ X _____ = 20/____
OS	20/____	20/____	OS: _____ +/- _____ X _____ = 20/____

Please select one of the following:

I have completed a comprehensive ophthalmologic examination on this patient. Please do not repeat this evaluation. Schedule patient directly for preoperative appointment. (Fax over relevant clinical notes)

OR

I would prefer Sugarland Eye & Laser Center to fully evaluate the patient with a comprehensive ophthalmic examination before counseling patient on cataract surgery.

Intraocular Lens Choice

Patient Prefers:

- Traditional Monofocal IOL
- Traditional Monofocal IOL (Monovision)
- Multifocal IOL
- Undecided

Postoperative Care

I would like the patient to return to my office

- for all postoperative care.
- for postoperative care after post-op day # ____
- once postoperative course is complete.

Patient is aware of shared billing and additional surgical and co-management costs for multifocal intraocular lens.

PLEASE FAX THIS FORM TO THE NUMBER ABOVE OR GIVE THIS FORM TO THE PATIENT TO BRING TO OUR OFFICE. THANK YOU VERY MUCH!

LASIK SPECIALISTS – DISEASES & SURGERY – ADULT & PEDIATRIC

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