Batchelet Eye

Phone 724-766-0986 • Fax 724-558-9960

CONSULT REQUEST

PATIENT NAME _____ PATIENT PHONE _____

DATE OF BIRTH _____ DATE OF EXAM _____

CONSULT TYPE: ☐ CATARACT ☐ OFFICE LASER ☐ GLAUCOMA ☐ OTHER _____

Referring Doctor's Signature _____

NOTES: **☐ MOST RECENT EXAM NOTE ATTACHED**

☐ IF PREFERRED, FILL OUT THE INFORMATION BELOW:

PREVIOUS SURGERY OR
EYE HEALTH PROBLEMS:

OLDEST REFRACTION: DATE _____

R _____

L _____

RELEVANT CLINICAL FINDINGS:

CURRENT REFRACTION:

IOP: R _____

L _____

R _____ 20/_____

L _____ 20/_____

SLIT LAMP:

FUNDUS:

DIAGNOSIS:

RECOMMENDATIONS:

PLEASE FILL OUT IF CATARCT CONSULT:

CONTACT LENS WEAR: ☐ SOFT ☐ ASTIGMATIC ☐ GP
*Please have patient remove contact lenses 7 days prior to their appointment if cataract consult

SUGGESTED REFRACTIVE GOAL: RIGHT: PLANO or _____

LEFT: PLANO or _____

IOL PREFERENCE: ☐ candidate for premium refractive options
☐ not a candidate for premium refractive options

POST-OP: This patient has chosen to have post-operative care delivered at: ☐ BE ☐ OUR OFFICE.