eye clinic of wisconsin™
One vision. Yours.®

Practice:
Doctor:
Address:
City, State, Zip:
Phone:
Fax:

Referral Form for Cataract Surgery

Dear Doctor: _____,
Surgeon's Name

An appointment has been requested for the following patient to see you in your office in _____, for consideration for cataract surgery in the right / left / both eye(s). (Note Location)

Name: _____ DOB: _____/_____/_____

Address: _____ State _____ Zip _____

Phone: _____ Alternate Phone: _____

Family Representative: _____ Phone: _____

Insurance Plan: _____ ID #: _____Self-Pay ☐

The most recent examination was on _____/_____/_____.

Visual Complaints: _____

Most Recent Refraction:

Sphere	Cylinder	Axis	Prism	Base	Add
		x			
		x			

Best Corrected Visual Acuity

OD 20/_____

OS 20/_____

IOP: _____OD/_____OS

Ocular History: ☐ Contact Lens Wearer ☐ History of Refractive Surgery

Other Pertinent Information: _____

_____

☐ **No, this will not be Co-Managed**

☐ **Yes, this will be Co-Managed**

I have discussed Co-Management with the patient named above.

_____ _____
Referring Physician Signature Date

Form completed by: _____

APPOINTMENT SCHEDULING

☐ Please call patient to schedule, note appointment below and fax back to my office. Initials: _____

Date: _____ Time: _____ Location: _____ Provider: _____

Please fax this completed form to: (715) 870-2401. Rev. 1/25/24