eye clinic of wisconsin™
One vision. Yours.®

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

Referral Form for Cataract Surgery

Dear Doctor: _____,

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	Best Corrected Visual Acuity	Best Corrected Near Visual Acuity
			x				OD 20/_____	OD 20/_____
			x				OS 20/_____	OS 20/_____

IOP: _____OD/_____OS

Ocular History: ☐ Contact Lens Wearer ☐ History of Refractive Surgery ☐ History of Glaucoma
Send Visual Fields

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 Provider Signature Date

Form completed by: _____

APPOINTMENT SCHEDULING

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

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

Please fax this completed form to: (715) 870-2401. Rev. 7/26