Cataract and Eye Consultants

Phone 724-617-2020 • Fax 724-453-4108

CONSULT REQUEST

PATIENT NAME ________________________________ PATIENT PHONE __________________________

DATE OF BIRTH ________________________________ DATE OF EXAM __________________________

CONSULT TYPE: ☐ CATARACT ☐ YAG ☐ OTHER ____________________

NOTES: ☐ **MOST RECENT EXAM NOTE ATTACHED – fill out post operative follow up information below**

☐ IF PREFERRED, FILL OUT THE INFORMATION BELOW:

PREVIOUS SURGERY OR
EYE HEALTH PROBLEMS:

OLDEST REFRACTION: DATE ______________________

R ____________________________________

L ____________________________________

RELEVANT CLINICAL FINDINGS:

IOP: R ___________

L ___________

CURRENT REFRACTION:

R ____________________________________ 20/_______

L ____________________________________ 20/_______

SLIT LAMP:

FUNDUS:

DIAGNOSIS:

RECOMMENDATIONS:

POST-OP: This patient has chosen to have post-operative care delivered at:
☐ CEC
☐ **OUR OFFICE – I have verified participation in the patient's insurance and accept responsibility to bill the patient's insurance for post operative care using -55 modifier**
*if no box is checked or above statement is not noted in the referring letter, CEC will perform and bill for all post op care

PLEASE FILL OUT IF CATARCT CONSULT:

CONTACT LENS WEAR: ☐ SOFT ☐ ASTIGMATIC ☐ GP
*Please have patient remove contact lenses 3 days prior to their appointment if catract consult

SUGGESTED REFRACTIVE GOAL: RIGHT: PLANO or ____________________

LEFT: PLANO or ____________________

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

Referring Doctor's Signature ________________________________