



Northeast Wisconsin Vision Center, Ltd.

REQUEST FOR CONSULTATION

FAX TO: 920.232.6552

Requesting Doctor: _____

Date: _____

Patient: _____

DOB: _____

Phone Number: _____

Address: _____

Insurance: _____

Policy #: _____

Referred to: Ophthalmology Dr. Merfeld Dr. Larson Dr. Raven

Reason for Consultation:

_____ Cataract _____ Glaucoma _____ Cornea
_____ Other: _____

Patient requests to co-manage post-operative care

Date of exam by OD: _____

Ophthalmic History: _____

Ophthalmic Medication: _____

Tonometry: OD _____ mm Hg

OS _____ mm Hg

Refraction/MR: OD _____ + _____ x _____ 20/ _____

OS _____ + _____ x _____ 20/ _____

Results of Dilated Exam:

Other Eye Disorders:

Comments: _____

Signature

Date