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. 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

Northeast Wisconsin Vision Center
Phone: 920-232-6550 Fax: 920-232-6552