CATARACT CONSULT REQUEST

Cataract and Eye Consultants
Phone 724-617-2020 • Fax 724-453-4108

PATIENT NAME _____

DATE OF BIRTH _____

REFERRING DOCTOR _____

DATE OF EXAM _____

CEC will call this patient to schedule:

PATIENT PHONE _____

Please send a copy of the current insurance card + photo ID for insurance verification if possible

PREVIOUS SURGERY OR EYE HEALTH PROBLEMS:

OLDEST REFRACTION: DATE _____

R _____ 20/_____

L _____ 20/_____

VISION DIFFICULTY: *(caused by cataract)* ☐ Reading ☐ Driving ☐ Other:

RELEVANT CLINICAL FINDINGS:

IOP: R _____

L _____

CURRENT REFRACTION:

R _____ 20/_____

L _____ 20/_____

SLIT LAMP:

FUNDUS:

CONTACT LENS WEAR: ☐ SOFT ☐ ASTIGMATIC ☐ GP
*Please have patient remove contact lenses 2 days prior to their appointment.

DIAGNOSIS:

RECOMMENDATIONS:

SUGGESTED REFRACTIVE GOAL: R _____

L _____

IOL PREFERENCE:

☐ I believe this patient would be interested in one of the premium refractive options to reduce their need of spectacles following surgery.
☐ I believe this patient would be happy with spectacles following surgery.
☐ This patient is not a candidate for premium lenses.
☐ I have NOT discussed IOL options. I would like CEC to discuss the refractive options with the patient.

POST-OP: This patient has chosen to have post-operative care delivered at: ☐ CEC ☐ OUR OFFICE.

_____date report faxed to CEC

Signature _____