CATARACT CONSULT REQUEST

SightLine Ophthalmic Associates
Phone 724-933-5588 • Fax 724-933-6051

PATIENT NAME _____ REFERRING DOCTOR _____

DATE OF BIRTH _____ ☐ I have scheduled an appointment for this patient.

DATE OF EXAM _____ ☐ I would like Sightline to call this patient to schedule:

PATIENT PHONE _____

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 have discussed Premium IOLs with this patient and he/she is:
- ☐ Ready to move forward with: ☐ TORIC IOL ☐ PRESBYOPIC IOL
- ☐ Interested in learning more about: ☐ TORIC IOL ☐ PRESBYOPIC IOL
- ☐ Not interested in premium IOLs
- ☐ Not a candidate

☐ I have NOT discussed IOL options. I would like SightLine to discuss this with the patient.

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

☐ Report Faxed to SightLine Signature: