

CATARACT CONSULT REQUEST

SightLine Ophthalmic Associates

Phone 724-933-5588 • Fax 724-933-6051

PATIENT NAME _____

I have scheduled an appointment for this patient.

DATE OF BIRTH _____

I would like Sightline to call this patient to schedule.

REFERRING DOCTOR _____

PATIENT PHONE _____

DATE OF EXAM _____

CURRENT PROBLEM AND PERTINENT OCULAR HISTORY:

CONTACT LENS WEAR: SOFT GP or Scleral Monovision Multifocal

*Please have the patient remove their contact lenses **3 days** prior to the appointment for **SOFT lenses** and **ASAP** for **RIGID lenses**. Long time RGP wearers will need to stabilize corneas for weeks or months without their contacts.

OLDEST REFRACTION: DATE _____

If considering MIGS, what is their

OD _____ 20/_____

current treatment: _____

OS _____ 20/_____

CURRENT REFRACTION: DATE _____

Glaucoma Type:

POAG

OD _____ 20/_____

Other: _____

OS _____ 20/_____

Stage of glaucoma:

SUGGESTED REFRACTIVE GOAL:

Mild Moderate Severe

OD _____

OS _____

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 SightLine to discuss the refractive options with the patient.

This patient has chosen to have post-operative care delivered at:

SIGHTLINE OUR OFFICE.

Signature _____