

Consultation Request



REFERRING DOCTOR

Name _____
Phone _____
Date of exam _____

PATIENT INFORMATION

Name _____
Phone _____
Date of birth _____

REASON FOR CONSULTATION OD OS OU

Cataract evaluation YAG laser evaluation Other _____

For cataract evaluation, please provide:

Recommended refractive error outcome: OD _____ OS _____ Prior refractive surgery? OD OS

IOL preference: Undetermined Multifocal Multifocal Toric
 Single-focus *The patient is aware of extra multifocal IOL costs for comanagement and surgery.*
 Toric *I have completed extra multifocal IOL counseling and testing to help confirm the patient's candidacy.*
 The patient wishes to return to my care for the extra post-op care as soon as condition is stable.

Glaucoma: Patient has mild to moderate OAG and is using topical medications. Consider their candidacy for micro invasive glaucoma surgery (MIGS, which includes iStent) at the time of cataract surgery. Enclosed are current VFs and/or ONH images. Highest known pressures are _____ mm Hg OD and _____ mm Hg OS. I understand MIGS is not available at all PCLI locations.

Corneal stability: Soft lens wearer RGP lens wearer Advised to leave contacts out _____ weeks before PCLI exam.

IMPORTANT NOTE: For accurate surgery, soft lenses must be left out at least 7 days prior and RGPs at least 3 weeks prior, or until corneal stability is confirmed.

CLINICAL FINDINGS

OD

OS

Dominant eye

Refraction (date _____) _____ 20/ _____ _____ 20/ _____

IOP: Air Applanation Other _____ mm Hg _____ mm Hg

Relevant exam findings _____

Recommendation to patient _____

APPOINTMENT

I have scheduled this patient to be seen at PCLI on: (date) _____ at (time) _____

I would like PCLI to phone this patient to schedule an appointment.

Contact patient about possible PCLI transportation. They understand shuttle service is limited to cataract and YAG surgery patients with transportation challenges within reasonable driving distance.

Signed _____
Referring Doctor