TOWER CLOCK
EYE CENTER

The difference is in sight.

Professional Solutions for Cataracts, Glaucoma & Cornea

REQUEST FOR CONSULTATION

FAX TO: 920.499.9636

Requesting doctor: _____ **Clinic location:** _____

Clinic phone & fax: _____ **Date:** _____

Patient: _____ **Phone:** _____ **DOB:** _____

Consultation appointment date: _____ **Time:** _____

Referred to: ☐ Tyson K. Schwiesow, MD ☐ Kurt A. Schwiesow, MD

☐ Matthew J. Thompson, MD ☐ Kunal S. Patel, MD ☐ Annette L. Giangiacomo, MD

☐ Michael Servi, OD ☐ Jacob Woldt, OD ☐ Jamie Myers, OD

Reason for consultation:

_____ Cataract _____ Glaucoma _____ Cornea

_____ Other: _____

☐ Patient requests to co-manage post-operative care
☐ History of elevated IOP/glaucoma
☐ History of significant dry eye
☐ History of retinal disease

Ophthalmic history: **Ophthalmic medication:**

Tonometry: OD_____ mm Hg

OS_____ mm Hg

Refraction: OD_____+_____x_____ 20/_____

OS_____+_____x_____ 20/_____

Slit lamp exam:

Fundus:

Comanage: ☐ Yes ☐ No

Comments: _____

_____

_____

_____ _____

Signature **Date**

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www.towerclockeyecenter.com