



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