# 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 _____

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 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.

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

_____ Report Faxed to SightLine

Signature _____