CATARACT CONSULT REQUEST

SightLine Ophthalmic Associates
Phone 724-933-5588 • Fax 724-933-6051

PATIENT NAME _____

DATE OF BIRTH _____

REFERRING DOCTOR _____

DATE OF EXAM _____

□ I have scheduled an appointment for this patient.

□ I would like Sightline to call this patient to schedule.

PATIENT PHONE _____

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 _____

OD _____ 20/_____

OS _____ 20/_____

CURRENT REFRACTION: DATE _____

OD _____ 20/_____

OS _____ 20/_____

SUGGESTED REFRACTIVE GOAL:

OD _____

OS _____

If considering MIGS, what is their current treatment:_____

_____

Glaucoma Type:
☐ POAG

☐ Other: _____

Stage of glaucoma:

☐ Mild ☐ Moderate ☐ Severe

IOP 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 (we plan to bill for the post op care and accept reimbursement)

Signature _____