eye clinic of wisconsin™
One vision. Yours.®

Referral Form Cataract Surgery

Practice:
Doctor:
Address:
City, State, Zip:
Phone:
Fax:

Dear Doctor: _____,
Surgeon's Name

An appointment has been requested for the following patient to see you in your office in _____, for consideration for cataract surgery in the right / left / both eye(s). *(Note preferred location on above line)*

Name: _____ DOB: _____/_____/_____

Address: _____ State _____ Zip _____

Telephone: _____ Alternate Number: _____

Insurance Plan: _____ ID #: _____ Self-Pay □____

Referring Physician: Please fax clear copy of both sides of patient's insurance card

The most recent examination was on ___/____/___.

Visual Complaints: _____

Most Recent Refraction:

Sphere	Cylinder	Axis	Prism	Base	Add

Best Corrected Visual Acuity

OD 20/_____

OS 20/_____

Applanation Tensions: _____OD/_____OS

Optional Additional Information: PAM: 20/____OD 20/____OS BAT (High): 20/_____OD 20/____OS

☐ **History of LASIK/Refractive** ☐ **Contact Lens Wearer**

Other Pertinent Information/Ocular History:_____

_____

_____
Provider"s Signature

☐ **Yes, this will be Co-Managed (Patient to sign below):**

It is my desire to have Dr. _____, my own optometrist, perform my follow-up care after my cataract surgery. In signing this consent, I acknowledge that I understand the following:

1. My optometrist will only provide my post-operative care if my surgeon determines that transfer of care is medically appropriate.
2. I have the choice of having my surgeon provide the post-operative care but have chosen to have my optometrist provide such care.
3. My optometrist, in return for providing post-operative care, will receive a portion of the surgical reimbursement fee.
4. If Medicare or health insurance does not cover all expenses, I may have a balance due with both the surgeon and the optometrist. However, the total amount due from me after insurance will be the same amount, whether or not my optometrist provides my post-operative care.
5. Even though my optometrist assumes my post-operative, I will continue to have the right to contact the surgeon during the post-operative period.

I further acknowledge that my surgeon and my optometrist, as well as their employees, will share with one another information relating to my health, my vision and this surgical procedure as they deem necessary to provide me with appropriate care and I hereby consent to such sharing of information.

_____ _____

Patient's Signature for Co-manage Care Date

APPOINTMENT SCHEDULING

□ Please call patient to schedule, note appointment below and fax back to my office. PSR Initials: _____

□ Please contact patient for billing information.

□ I have already scheduled an appointment on the patient's behalf, as noted below:

Please fax this completed form to: (715) 261-8665 or (715) 261-8671