



# The Eye Center

OF SOUTHERN INDIANA

## Request for Consultation Form

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient address: \_\_\_\_\_

Phone: \_\_\_\_\_

City / Zip: \_\_\_\_\_

SSN: \_\_\_\_\_

### Insurance Information:

Primary Medical Insurance: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

**\*\*Attach copy of medical insurance card\*\***

### Consultation Requested For:

\_\_\_\_ Cataract (\_\_\_\_OD \_\_\_\_OS)

\_\_\_\_ Posterior Capsule Opacification (\_\_\_\_OD \_\_\_\_OS)

### Documentation needed for Cataract Surgery &/or Yag PC:

\_\_\_\_ Impaired visual function due to cataract and a change in glasses prescription is not recommended. The patient needs cataract surgery.

\_\_\_\_ Impaired visual function due to posterior capsular opacification and a change in glasses prescription is not recommended. The patient needs YAG laser capsulotomy.

Best corrected VA OD \_\_\_\_ / \_\_\_\_ with a refraction of \_\_\_\_\_

OS \_\_\_\_ / \_\_\_\_ with a refraction of \_\_\_\_\_

### Comanagement:

\_\_\_\_ Please comanage case with me if the patient prefers.

\_\_\_\_ I prefer no comanagement for this case, please.

\_\_\_\_ Other / Comments:

### Referring Doctor:

Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_

R. Daniel Grossman, M.D. Chad Huck, O.D. Steven E. Holbrook, O.D. Warren J. Chang, M.D.  
Joseph M. Mackey, M.D. Jason P. Gray, O.D. Frank N. Hrisomalos, M.D. Andrew Huck, M.D.

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