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Referral for Cataract Evaluation Co-Management Form

Date: _____

Referring Doctor _____

Fax Number _____

Patient Name _____

PLEASE FAX OR SEND WITH PATIENT.

Surgeon: James P. Gills, MD Pit Gills, MD

Visual Needs: (Check the patient's primary interests / needs)	<u>NEAR</u>	<u>INTERMEDIATE</u>	<u>DISTANCE</u>
	<input type="checkbox"/> Fine Print	<input type="checkbox"/> Computer	<input type="checkbox"/> Golf
	<input type="checkbox"/> Sewing	<input type="checkbox"/> Dining Table/Cooking	<input type="checkbox"/> Driving
	<input type="checkbox"/> Phonebook	<input type="checkbox"/> Playing Cards	<input type="checkbox"/> Movies/TV
Patient Priority / Goal:	<input type="checkbox"/> Maximize freedom from glasses <input type="checkbox"/> Monovision ___ Previous history of monovision <input type="checkbox"/> Maximum distance vision		
Target Refraction _____ RE		LE _____	
Patient Interested in:	<input type="checkbox"/> Presbyopic IOL	<input type="checkbox"/> Bilateral Distance	<input type="checkbox"/> Monovision
Brochure Given:	<input type="checkbox"/> Presbyopic IOL <input type="checkbox"/> Tecnis		

RE	Preoperative Findings	LE
Refraction _____	VA _____	Refraction _____
IOP _____	IOP _____	VA _____
Cornea		
<input type="checkbox"/> Astigmatism		<input type="checkbox"/> Astigmatism
<input type="checkbox"/> Pterygium		<input type="checkbox"/> Pterygium
<input type="checkbox"/> Fuchs'		<input type="checkbox"/> Fuchs'
<input type="checkbox"/> Keratoconus		<input type="checkbox"/> Keratoconus
<input type="checkbox"/> Prior Refractive Surgery		<input type="checkbox"/> Prior Refractive Surgery
Lens		
<input type="checkbox"/> Cataract		<input type="checkbox"/> Cataract
<input type="checkbox"/> IOL		<input type="checkbox"/> IOL
Fundus		
Macula _____		Macula _____
Periphery _____		Periphery _____
Vitreous _____		Vitreous _____
C/D Ratio _____		C/D Ratio _____

Comments

Patient Signature: _____ Referring Doctor's Signature: _____