



The Eye Center of Fort Wayne

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PATIENT CONSULTATION REPORT

Referring Doctor: _____ Appointment Date: _____	Patient Name: _____ Address: _____ City: _____ Phone: _____
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Ocular Examination

Subjective complaint: _____

Refraction: OD _____ 20/ _____ IOP: OD _____
 OS _____ 20/ _____ OS _____

Cataract Consultation Diagnosis: _____

Effects on Daily Living: Reading Glare Work Hobbies _____

Evaluate the surgical necessity of the cataracts

I feel that this patient would benefit visually from cataract surgery

Although there are other conditions which restrict the correctable vision, in my opinion there would be a qualitative benefit with cataract surgery to improve the patient's lifestyle.

Desired post-operative refractive error: OD _____ OS _____

Discussed premium IOL: Multifocal Toric

With the patient's consent, I wish to participate in co-management.

Patient Consultation Consultation Type: Glaucoma Retinal Neuro

OD OS OU Corneal Oculo-plastic Other

Description: _____

Management Please evaluate and manage this patient's condition accordingly.

I would prefer sharing the responsibility of the care of this patient's condition.

I am sending this patient for a second opinion, and will continue to manage the condition myself.

Signature of examining doctor X _____ **Date** _____