

Request for Consultation

Please complete and fax to 1-414-386-5245

Summit Eye Care – Wauwatosa
10425 W. North Ave #140
Wauwatosa, WI 53226
Phone: 414-877-6414

Summit Eye Care – Menomonee Falls
N89 W16785 Appleton Ave #3
Menomonee Falls, WI 53051
Phone: 262-253-4000

Referring Doctor: _____

Practice Name / Location: _____ Office Phone #: _____

Patient Name: _____ DOB: _____

Phone #: _____ E-Mail: _____

Location:

Wauwatosa

Menomonee Falls

Services Requested:

- Cataract Evaluation
- Refractive Surgery Evaluation
- Lid Lesion

- Laser: YAG / SLT / LPI
- Medical Consult: _____

- Testing Only
 - OCT (Type: _____)
 - Topography
 - Axial Length

- HVF (type: _____)
- Pachymetry

If Surgery is recommended, I'd like to co-manage the patient's post-op care if the surgeon feels medically appropriate

If surgery is recommended, I'd prefer Summit Eye of Wisconsin to assume the patient's post-op care and will resume the general care of the patient after the post-op period

Ocular Findings:

Exam Date: _____

Refraction OD: _____ VA: 20/____

OS: _____ VA: 20/____

IOP OD: _____ OS: _____

Pertinent exam findings / notes:

OD: _____

OS: _____

OD

OS

