

Cavanaugh Eye Center
 6200 W. 135th St. Suite 300
 Overland Park, KS 66223
 Phone: (913) 897-9200
 FAX: (913) 897-9233



Premium IOL Cataract / RLE Consultation Request Form:

<p>Referral Doctor: _____</p> <hr/> <p><u>Required Patient Information:</u></p> <p>ccVA: OD 20 / _____ OS 20 / _____</p> <p>Pupils (Mesopic): OD _____ OS _____</p> <p>Manifest Refraction:</p> <p>OD: _____</p> <p>OS: _____</p> <p>Cycloplegic Refraction (for RLE only)</p> <p>OD: _____</p> <p>OS: _____</p> <p>Dominant Eye: OD OS</p> <p>Non Dominant Target:</p> <p><input type="checkbox"/> Plano</p> <p><input type="checkbox"/> -1.00</p> <p><input type="checkbox"/> Other _____</p>	<p>Patient Name: _____</p> <p>Patient Phone: _____</p> <p>Consultation Scheduled? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Should we contact the patient? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>Preferred Location: <input type="checkbox"/> Overland Park <input type="checkbox"/> Topeka</p> <p>NOTES: _____</p> <hr/> <p>Dry Eye Assessment:</p> <p style="padding-left: 40px;">Schirmers Test OD _____ mm OS _____ mm</p> <p style="padding-left: 40px;">Rx for Optive, Omega 3 & Restasis? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Pertinent Slit Lamp Findings:</p> <p>_____</p> <p>_____</p> <p>_____</p> <hr/> <p>Dilated Fundus Exam Normal? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><u>Purpose of Consultation:</u> (circle all that apply) OD OS OU</p> <p><input type="checkbox"/> Cataract Evaluation <input type="checkbox"/> Refractive Lens Exchange <input type="checkbox"/> YAG <input type="checkbox"/> Phakic IOL <input type="checkbox"/> LASIK / PRK</p> <p><input type="checkbox"/> Cornea Evaluation <input type="checkbox"/> Other</p> <hr/> <p><input type="checkbox"/> I will Co-Manage this patient? <input type="checkbox"/> YES <input type="checkbox"/> NO at: <input type="checkbox"/> 1 Day <input type="checkbox"/> 1 Week <input type="checkbox"/> 1 Month</p> <p><input type="checkbox"/> I have discussed our Post-Operative Co-management and billing arrangement.</p> <p><input type="checkbox"/> I have educated the patient on Premium Presbyopic IOL options and have given the Cataract Surgery Handout.</p> <p><input type="checkbox"/> I have educated the patient to discontinue contact soft contact lenses for at least one week and RGPs for 1 month + 1 week for each decade of wear prior to the pre-op evaluation.</p> <p>Doctor's Signature _____</p>	

Fax this form to (913) 897-9233