Fisher-Swale-Nicholson Eye Center
We help you see your best.
with
Solutions In Sight
Laser and Surgery Suite

# FAX: (815) 315-4372

## CONSULTATION REQUEST

**Referral to:** ◯ **Dr. Swale M. D.** ◯ **Dr. Franklin M. D.** ◯ **Dr. Nicholson O.D.**

Patient's full name _____ DOB _____
Patient address _____ **Phone** _____
Referring Doctor:_____ Appt. Time and date: _____
If more than one office, specify location: _____
Office phone:_____Fax:_____
Patients medical insurance:_____
Preliminary Diagnosis/Concern: _____
History:_____

VA OU: _____ OD: _____ OS: _____ IOP: OD _____ OS:_____

**Reason for referral:**

- ○ Vision correction evaluation
  - ○ Lasik / PRK
  - ○ Visian ICL
  - ○ Clear lens exchange

- ○ Cataract
  - ○ Standard
  - ○ Toric
  - ○ Multifocal RESTOR

- ○ YAG Posterior Capsulotomy
- ○ Glaucoma
- ○ SLT
- ○ Laser peripheral iridotomy
- ○ Macular degeneration
- ○ Strabismus
- ○ Ectropion / entropion
- ○ Diabetes
- ○ Other: _____

**For cataracts**: Was the patient provided with a new glasses' prescription? ◯ Yes ◯ No

**How is the patient's vision affecting their daily lifestyle and activities? ****

- ○ Glare/Halos at night
- ○ Unable to see the TV or computer
- ○ Hunting/Golfing
- ○ Unable to see road signs
- ○ Trouble reading fine print
- ○ Playing games/cards

Notes:_____
_____