TALLEY EYE CARE

812.424.2020 | 800.489.2020 | 812.424.3000 fax | www.talleyeyecare.com

From: _____

Date: _____

To: ☐ D. Sommerville ☐ T. Brummer ☐ D. Silvera
☐ A. Parhiz ☐ N. Pelsor ☐ M. Kalia

Patient Name: _____ **DOB:** _____

Phone Number: _____

Are you a participating provider for this patient's medical insurance plan?
☐ Yes ☐ No
Do you wish to participate in the post-op co-management for this patient?
☐ Yes ☐ No

Consult Request:
☐ Cataract ☐ Retina
☐ LASIK ☐ Other

YAG:
☐ Surgery
☐ Evaluation

Request LASIK Info:
☐ Call Patient
☐ Send Literature

Current Glasses RX:
OD: _____
OS: _____
Add: _____

Manifest:
OD: _____
OS: _____

BCVA:
OD: _____
OS: _____

Glare:
OD: _____
OS: _____

Is the patient a contact lens wearer? ☐ Yes ☐ No ☐ Past ☐ Present

Contact Lens RX:
OD: _____
OS: _____

BCVA
OD: _____
OS: _____

Monovision? ☐
OD: Distance / Near
Multifocal? ☐

Patient Complaints

☐ Difficulty reading small print
☐ Difficulty driving in bright light
☐ Difficulty driving at night
☐ Difficulty reading traffic signs
☐ Difficulty watching TV
☐ Difficulty with glare and light sensitivity
☐ Difficulty doing hobbies
☐ Difficulty writing checks, cards
☐ Other

Additional information: _____

_____

_____