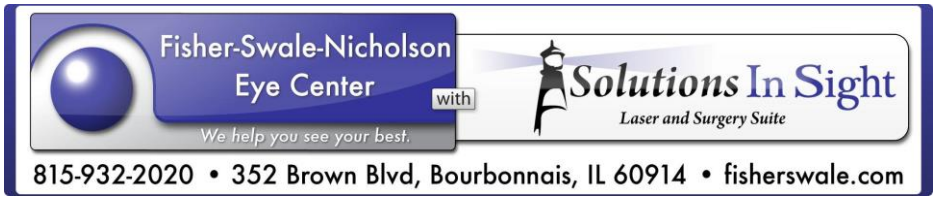

CONSULTATION REQUEST

Referral To: _____ Dr. Jerome A. Swale, MD

Patient Name: _____ DOB: _____
Patient Address:_____ Phone: _____
_____
Referring Doctor: _____ Appt. Time and Date: _____
If more than one office, specify location: _____
Office Phone: _____ Office Fax:_____

Preliminary Diagnosis/Concern: _____
History:_____

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

Reason for referral:

- ☐ **Consultation with Diagnostic Studies and Treatment as Indicated**
- ☐ **Consultation Only**
- ☐ **Diagnostic Testing Only:**
  - ☐ **Visual Field**
  - ☐ **Corneal Topography**
  - ☐ **OCT**
  - ☐ **Fundus Photos**
  - ☐ **Pachymetry**
  - ☐ **Gonioscopy**

This patient is being referred to you for evaluation/treatment of:

- ☐ **Vision Correction Evaluation**
  - ☐ **Lasik**
  - ☐ **Visian ICL**
  - ☐ **Clear Lens Exchange**
- ☐ **Cataract**
  - ☐ **Standard**
  - ☐ **Toric**
  - ☐ **Multifocal ReSTOR**
- ☐ **YAG Posterior Capsulotomy**
- ☐ **Glaucoma**
- ☐ **SLT (Selective Laser Trabeculoplasty)**
- ☐ **Laser Peripheral Iridotomy**
- ☐ **Macular Degeneration**
- ☐ **Strabismus**
- ☐ **Ectropion/Entropion**
- ☐ **Diabetes**
- ☐ **Other:_____**

Notes:_____
_____
_____

"Delivering exceptional care & service to our referring doctors & their patients as we provide optimum solutions in sight"

Fax to: 815-937-0060