BAYCARE CLINIC®
EYE SPECIALISTS

Phone: (920) 327-7000 Toll Free: (877) 462-9465 Fax: (920) 327-7005

REFERRAL FORM FOR CATARACT SURGERY

Date: _____

An appointment is being requested for the following patient to see you at the Green Bay location for cataract surgery.

Patient Name: _____ **DOB:** _____/ _____/ _____

Address: _____ _____ State: _____ Zip: _____

Telephone: _____ Alternate Number: _____

The most recent examination was on _____/ _____/ _____.

Visual Complaints: _____

_____

Most Recent Refraction:

Sphere	Cylinder	Axis	Distance VA	Add	Near VA	Prism
		x	20/			
		x	20/			

IOP: OD_____ OS_____ Time**:** _____ Auto K's: OD_____/_____@_____ OS_____/_____@_____

Other Pertinent Information**:** Ocular History, Medical History, Current Medications. _____

_____

_____

***Please have patient bring current medication list to appointment w/surgeon.**

_____ _____

OD/Physician Printed Name OD/Physician Signature

Referral Office Location**:** _____

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