SILVERSTEIN EYE CENTERS P.C.
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## Patient Referred to:

◯ Steven M. Silverstein MD, FACS ◯ Jeff L. Lookhart OD

## Request For Consultation

Patient Name _____ Date of Birth ___/___/___

Address _____

City _____ State _____ Zip _____

Phone Numbers: Home (___) ___-_____ Work (___) ___-_____

Mobile (___) ___-_____ E-mail _____

Insurance _____

## Reason for Consultation / Referral

◯ Acute Care
◯ Corneal Evaluation
◯ Cataract / PCO Evaluation
◯ Refractive Surgery Evaluation
◯ Glaucoma Evaluation
◯ Retinal Evaluation
◯ Other: _____

## Exam Information

Best Corrected VA: OD 20/_____ Tonometry: OD_____
OS 20/_____ (App / NCT) OS_____

Exam Findings: _____

_____

Other: _____

_____

If Cataract / PCO / Refractive Surgery Evaluation, can patient be co-managed: ◯ Yes ◯ No

If able to be co-managed, I would prefer to see patient back for:

◯ 1-Day P/O ◯ 1-Week P/O ◯ 1-Month P/O ◯ Final Rx

Referring Doctor (Please Print) _____

Office Phone Number (___) ___-_____ Today's Date ___/___/___