



Appointment Date: _____ / _____ / _____ Time: _____

Patient Referred to:

- Steven M. Silverstein MD, FACS 4240 Blue Ridge Blvd, Suite 1000
- Timothy M. Stout MD Kansas City, MO 64133
- Jeff L. Lookhart OD Office: (816) 358.3600 Fax: (816) 358.1887

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- Suzanne R. Adkins OD, FAAO 201 N 2nd Street, Odessa, MO 64076
 - Office: (816) 230.5321 Fax: (816) 565.2288

Request For Consultation

Patient Name _____ Date of Birth _____ / _____ / _____

Phone (_____) _____ - _____ ___ home ___ work ___ cell

Reason for Consultation / Referral

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

Exam Information

Refraction: OD _____ X _____ Best Corrected VA: OD 20/ _____

OS _____ X _____ OS 20/ _____

IOP: OD _____

OS _____ Time and Method: _____

Exam Findings: _____

If Cataract / PCO / Refractive Surgery Evaluation, can patient be co-managed: Yes

If able to be co-managed, I would prefer to see patient back for: No

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

Referring Doctor (Please Print) _____

Office Phone Number _____ Today's Date _____ / _____ / _____