SILVERSTEIN EYE CENTERS P.C.
SilversteinEyeCenters.com

Consultation Referral Form

Appointment Date: ____/____/____ Time: _____

Patient Referred to:

◯ Steven M. Silverstein MD, FACS
◯ Timothy M. Stout MD, Retina Specialist
◯ Suzanne R. Adkins OD, FAAO

4240 Blue Ridge Blvd, Suite 1000
Kansas City, MO 64133
Office: (816) 358.3600 Fax: (816) 358.1887

◯ Amber B. Troyer OD

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 ◯ 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 ____/____/____