TOWER CLOCK EYE CENTER

TYSON SCHWIESOW, M.D.
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MICHAEL SERVI, O.D.

PROFESSIONAL SOLUTIONS FOR GLAUCOMA, CORNEA, AND CATARACTS

REQUEST FOR CONSULTATION **FAX TO: 920.499.9636**

Requesting Doctor: _____ Today's date: _____

Patient: _____ DOB: _____

Consultation Appointment date: _____ Time: _____

Referred to: Tyson K. Schwiesow_____ Kurt A. Schwiesow_____ Matthew J. Thompson_____

Reason for Consultation: _____ Cataract _____ Glaucoma _____ Cornea

_____ Cataract with presbyopia or astigmatism-correcting IOL

_____ Refractive surgery

_____ Other: _____

☐ Patient requests to comanage post-operative care

Ophthalmic History: Ophthalmic Medication:

Tonometry: OD _____ mm Hg

OS _____ mm Hg

Refraction: OD _____ + _____ x _____ 20/_____

OS _____ + _____ x _____ 20/_____

Slit Lamp Exam:

Fundus:

Comments:

Signature: _____ Date: _____

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