TOWER CLOCK
EYE CENTER
The difference is in sight.

PROFESSIONAL SOLUTIONS FOR CATARACTS, GLAUCOMA & CORNEA

REQUEST FOR CONSULTATION

FAX TO: 920.499.9636

Requesting Doctor: _____ Date: _____

Patient: _____ DOB: _____

Consultation Appointment Date: _____ Time: _____

Referred to: ☐ Tyson K. Schwiesow ☐ Kurt A. Schwiesow ☐ Matthew J. Thompson

Reason for Consultation:

_____ **Cataract** _____ **Glaucoma** _____ **Cornea**

_____ **Other:** _____

☐ Patient requests to co-manage post-operative care

☐ History of elevated IOP/glaucoma

☐ History of significant dry eye

☐ History of retinal disease

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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www.towerclockeyecenter.com