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: _____ **Clinic location:** _____

Clinic phone: _____ **Date:** _____

Patient: _____ **Phone:** _____ **DOB:** _____

Consultation appointment date: _____ **Time:** _____

Referred to: ☐ **Tyson K. Schwiesow, MD** ☐ **Kurt A. Schwiesow, MD**
☐ **Matthew J. Thompson, MD** ☐ **Kunal S. Patel, MD**

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**

1087 WEST MASON STREET • GREEN BAY, WI 54303
920.499.3102 or 877 MY EYE MD (877.693.9363) • Fax: 920.499.9636
www.towerclockeyecenter.com