14101 Fairview Drive, Suite 350 • Burnsville, MN 55337
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www.clariseyecare.com

Consultation Request

Date: ___________________

Referring Provider: ___________________________

Clinic Name: ___________________________________

Contact Person: ______________________________

Phone: _________________ Fax: _________________

Patient Name: ____________________________

DOB: _____________ Patient Ph: _________________

Insurance Co: ________________________________

Insurance ID: ________________________________

Interpreter ☐ Yes ☐ No Lang: __________________

TYPE OF CONSULT:

☐ Cataract
☐ LASIK/Refractive Surgery
☐ Lids/Blepharoplasty
☐ Glaucoma
☐ Minor Procedure ____________________________
☐ Other ______________________________________

TESTING REQUEST:

☐ Fundus Photos
☐ OCT
☐ Corneal Topography
☐ Visual Field
☐ Pachymetry
☐ Other _______________________

Scheduling an Appointment

☐ We would prefer Claris calls the patient to schedule.

☐ We have scheduled the appointment for the patient.
Date: _____________________

Shared Care for Cataract Surgery

If Dr. Carlson recommends surgery;

☐ I would like to co-manage in the aftercare of this patient if Dr. Carlson feels that is medically appropriate. I will contact Dr. Carlson immediately if any complications arise related to the surgery.

**Complex surgery may require a post-operative appointment with the surgeon and shared care will resume after the patient is cleared.

☐ I would prefer Dr. Carlson assumes the after care for this patient and will resume routine care with the patient after the post-operative period.

After consultation is complete, Claris will provide an exam note, surgery and/or treatment plan and co-management details if applicable.

Provider Notes:____________________________
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Please fax this form along with exam notes to 952.522.4901 or e-mail info@clariseyecare.com.

**Please do not hesitate to reach out to our office with any questions.
Thank you for allowing us to share in the care of your patient!**