

# 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
- YAG CAP
- YAG PI
- 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

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](mailto: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!**