TALLEY EYE INSTITUTE

812.424.2020 | 800.489.2020 | 812.424.3000 fax | www.talleyeyeinstitute.com

From: _____

Office Location: _____

Date: _____

To: ☐ Thomas A. Brummer, M.D. ☐ Drew N. Sommerville, M.D. ☐ Nathan Pelsor, O.D.
☐ Dwight A. Silvera, M.D. ☐ Clinton R. Ellingson, M.D. ☐ Monica Kalia, O.D.

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City, St, Zip:** _____

Phone Number: _____

Does the patient reside in a nursing home or a similar facility? ☐ Yes ☐ No

Are you a participating provider for this patient's medical insurance plan? ☐ Yes ☐ No

Do you wish to participate in the post-op co-management for this patient? ☐ Yes ☐ No

Consult Request:

☐ **Cataract** ☐ **YAG Cap** ☐ **Cornea** ☐ **Retina** ☐ **LASIK**

☐ **Other**: _____

_____

Request LASIK Info:

☐ Call Patient

☐ Send Literature

☐ **Glaucoma** (please send past records and VFs as possible)

Reason for Referral:

☐ Diagnostic Question ☐ Surgical Evaluation ☐ Incisional Surgery

☐ Treatment Issue ☐ Iridotomy ☐ SLT

Do you wish to provide glaucoma care for this patient in the future? □ Yes □ No

Current Glasses Rx:	**Manifest:**	**BCVA**	**Glare:**
OD: _____	**OD:** _____	**OD:** _____	**OD:** _____
OS: _____	**OS:** _____	**OS:** _____	**OS:** _____
Add: _____			

Does the patient wear contact lenses? ☐ Yes ☐ No ☐ Past ☐ Present

Contact Lens Rx:	**BCVA:**	**Monovision?** ☐
OD: _____	**OD:** _____	**OD:** Distance / Near
OS: _____	**OS:** _____	**Multifocal?** ☐

Additional Information: _____

_____

_____