HERZIG EYE INSTITUTE

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CATARACT CONSULTATION FORM

☐ Dr. Herzig ☐ Dr. Eplett
☐ Dr. Taylor ☐ Dr. Choudhry
☐ Dr. Ma

Patient Name: _____ **Date of Birth:** _____
(MM / DD / YYYY) *Age*

Address: _____

Phone Number: **Home** ( ) _____ **Work** ( ) _____

Cell ( ) _____ **Health Card #** _____ **Version Code** _____

Email Address: _____

(Please complete all requested information)

History / Comments: _____

_____

_____

Date of Examination: _____ *(MM/DD/YYYY)*

Present Correction

OD: _____ _____ X _____ 20/

OS: _____ _____ X _____ 20/

IOP:

OD _____ *OS* _____

Dominant Eye:

OD ____ *OS* ____

Slit lamp exam:

OD *OS*

Fundus exam:

OD *OS*

Discussed:

Advanced Technology Package: ☐ YES ☐ NO

Aspheric IOL : ☐

Toric IOL : ☐

Multifocal IOL : ☐

Patient interested in:

Advanced Technology Package: ☐ YES ☐ NO

Aspheric IOL : ☐

Toric IOL : ☐

Multifocal IOL : ☐

Referring Doctor / Optometrist: _____

Referring Number: _____

Address: _____

Phone #: _____ **Fax #:** _____

Email address: _____

Meeting Date: _____

Tx Date: _____

Comments: _____

_____

_____