Weatherford
EYECARE CENTER

Thank you for choosing the Weatherford Eyecare Center. We look forward to partnering with you in your patient's care.

REQUEST FOR CONSULTATION

Referring Provider Information

Referred by: _____ MD/DO/OD other _____ Medical Group: _____

Phone: _____ - _____ - _____ Fax: _____ - _____ - _____ PCP: _____

Address: _____ City: _____ Zip: _____

This form completed by: _____ Direct Phone: _____ - _____ - _____

Patient Information ***(Please provide copy of demographics, insurance card(s) and pre-authorization information, if required)***

Last Name: _____ First Name: _____ MI: _____

DOB: _____/_____/_____ Gender: M / F Preferred Phone: _____ - _____ - _____

Patient's Address: _____ City: _____

State: _____ Zip: _____ Interpreter Requested: Y / N Language: _____

Reason for Referral

Diagnosis/ICD-9: _____

Reason for Visit: Cataracts □ Cornea □ Culturing □ Eye Emergency □ Eye Lids/Lesion Removal □

Glaucoma □ High Risk Meds □ Neuro □ Pediatric □ Red Eye □ Retina □ Vision Correction (LASIK) □

Type of Service Requested: Consultation □ 2nd Opinion □ Follow Up □ Minor Surgery □ Specify other

_____

_____

Optometric Physician Requested: Dr. Paul C. Tisdal □ Dr. Jaclyn A. Munson □ Findings Report: Y / N

Documentation Required ***(please fax with this form)***

- **Most current clinical notes and test results i.e. history, physical, Labs/MRI/CT/X-ray results**
- **Copies of any OCT/VF/Surgical/Refractive/Cycloplegic information**

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