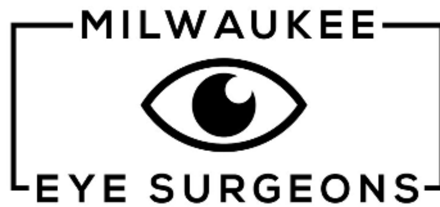


Referral for Cataract Surgery

______________________		______________________
Patient Name		Referring Doctor
____________	____________	______________________
Patient DOB	Patient Phone #	Referring Clinic

Please include the most recent clinic notes and copies of any ancillary testing performed (check if performed and enclosed).

- ☐ Topography
- ☐ Macula OCT
- ☐ Keratometry
- ☐ Schirmer's Testing

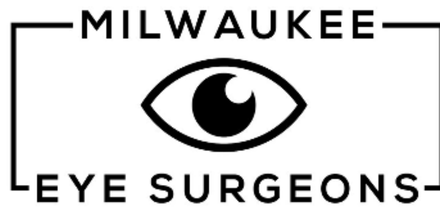
Pre-Operative counseling

- ☐ Discussed lens options
- ☐ Performed informed consent for co-management of care

Patient Preferences

- ☐ Monofocal lens
- ☐ Femtosecond laser
- ☐ Multifocal/Extended Depth of Focus (EDOF) lens
- ☐ Desires co-management (please complete consent form)

Phone: 414-377-5550 | Fax: 414-377-5550 | Email: info@MilwaukeeEyeSurgeons.com
www.MilwaukeeEyeSurgeons.com | 16650 W Bluemound Rd, Suite 400B, Brookfield, WI 53005



Consent for planned co-management after eye surgery

Patient Name:____

Dr. Weinlander will be performing ________________surgery on me. Because of __________________________ ____________ , I would like Dr. _____________________ to perform my postoperative follow-up care. I have discussed this postoperative selection with my surgeon, Dr. Weinlander.

I understand that my comanaging optometrist Dr. ___________________ will contact my surgeon immediately if I experience any complications related to my eye surgery.

I understand that I may contact Dr. Weinlander at any time after the surgery.

Patient Signature:____ Date: _______________

Optometrist Confirmation

I have agreed to provide follow-up care for ________________________. I will see the patient after surgery when Dr. Weinlander notifies me that he is releasing the patient to my care. I agree to notify Dr. Weinlander immediately should any complications arise and to provide written progress reports while the patient is under my care during the post-operative period.

Optometrist Signature: ____ Date: _______________