NEBRASKA LASER EYE™
ASSOCIATES

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CATARACT REFERRAL

Referring Dr. _____ Date ____/____/____
Patient: _____ DOB ____/____/____ Sex: M F
Pt's address: _____ Phone (___)_____
City: _____ State _____ Appointment date: ___/___/___

This patient is currently interested in a cataract evaluation and possible surgery.

Patient Complaint: _____

Examination

Uncorrected visual acuity OD 20/____
OS 20/____

Manifest Refraction OD _____ 20/_____
OS _____ 20/_____

IOP OD _____ mmHg
OS _____ mmHg

OD	(Circle appropriate condition)	**OS**
clear blepharitis	**Lids / Lashes**	clear blepharitis
clear injected	**Conjunctiva**	clear injected
deep and clear cells	**Anterior Chamber**	deep and clear cells
clear	**Cornea**	clear
Nuclear Cortical PSC	**Lens**	Nuclear Cortical PSC
0.____	**Disk**	0.____
normal	**Macula**	normal
normal	**Vessels**	normal
normal	**Periphery**	normal

Comments: _____

This patient would like to be co-managed with our office following cataract surgery. ☐Yes ☐No