St. Luke's Cataract & Laser Institute
Life Changing Vision®

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800-282-9905 • 727-943-3338 • StLukesEye.com

Cataract Evaluation Referral

PLEASE FAX TO: 727-943-3109

This form must be thoroughly completed to co-manage with St. Luke's.

Requesting Doctor: _____ Medicare Provider: ☐YES ☐NO
First Name Last Name

Address (if multiple):_____

Patient's Name:_____ DOB: _____ Phone: (_____)_____

Referring to: ☐ Pit Gills, MD ☐ Jeffrey Wipfli, MD ☐ Brandon Rodriguez, MD ☐ Robert M. Lee, MD

PERTINENT PATIENT HISTORY:
Ocular Medications: _____
Dominant Eye:_____ Diabetic: Yes / No A1C: _____ Mono CL Wearer: Distance Eye _____ Near Eye _____ Multifocal CL:_____
Medications_____

	RIGHT EYE N/A All ☐	**LEFT EYE** N/A All ☐
Astigmatism:	☐N/A_____	☐N/A_____
Amblyopia:	☐N/A_____	☐N/A_____
Macular Degeneration:	☐N/A_____	☐N/A_____
Diabetic Retinopathy:	☐N/A_____	☐N/A_____
Dry Eye:	☐N/A_____	☐N/A_____
Glaucoma:	☐N/A_____	☐N/A_____
Prior Refractive Sx:	☐N/A_____	☐N/A_____
Other:	☐N/A_____	☐N/A_____

Preoperative Findings:	**RIGHT EYE**	**LEFT EYE**
Current Glass	_____	_____
Vision:	BCDVA: _____ BCNVA: _____	BCDVA: _____ BCNVA: _____
IOP:	_____	_____
Adnexa:	☐WNL_____	☐WNL_____
Conjunctiva:	☐WNL_____	☐WNL_____
Cornea:	☐WNL_____	☐WNL_____
A/C:	☐WNL_____	☐WNL_____
Iris:	☐WNL_____	☐WNL_____
Lens:	☐WNL_____	☐WNL_____
Optic Nerve:	☐WNL_____	☐WNL_____
Macula:	☐WNL_____	☐WNL_____
Vitreous:	☐WNL_____	☐WNL_____
Vessels & Periphery:	☐WNL_____	☐WNL_____

Patient's Post-operative Vision Goals: _____
☐ **I have reviewed lens options with patient including: Presbyopic IOL, Astigmatism Reduction (Toric IOL and/or LRI), Standard IOL (targeting distance or near vision), Monovision, etc.**

My recommendation is: _____
Include any information that will help us match the lens choice with the patient's uncorrected post-op vision goals

Recommended Target: _____ _____

Referring Doctor's Signature: _____ Date of Exam: _____