WHATCOM EYE SURGEONS

A Division of Northwest Eye Surgeons of Seattle

Consultation Request Form

If you need your patient seen urgently (within 72 hours), please call our office directly at 1-800-826-4631

Date of Referral: _____ / _____ / _____

Patient's Name: _____ Date of Birth: _____ / _____ / _____

Patient's Cell Phone: _____ Preferred method of contact: ❑ Phone ❑ Text ❑ Email

Patient's Home Phone: _____ Patient Email: _____

Reason for Referral

❑ Retina ❑ Oculoplastics ❑ Refractive ❑ Strabismus ❑ Yag Cap / PCO eval

❑ Cornea ❑ Cataract* (order pre-operative testing including corneal topography & biometry)

*Does your patient also have glaucoma? ❑ Yes ❑ No

For Glaucoma ***Please only submit our Glaucoma Consultation Request Form*

❑ Other _____

Consulting Whatcom Eye Surgeons' Physician: _____

Okay to schedule with a different WES provider if available sooner? ❑ Yes ❑ No

Clinical findings/areas of concern: _____

_____

_____

_____

_____

Cataract Co-Management:

❑ Patient wishes to return to my office for post-op care.

❑ Patient is aware of the shared billing arrangements and the additional surgical and co-management fees associated with Vision Correction.

❑ Patient prefers WES to manage surgical post-op care.

Your Information

Referring Doctor: _____ Practice: _____

Address: _____

Phone: _____ Fax: _____

Please fax to Whatcom Eye Surgeons (360) 676-6298.