Surgery Consult Form

BOX BUTTE GENERAL HOSPITAL

WEBB eyecare

Dr. Edward Stevenson | **Cataract Pre OP**

Phone: 308.762.3124
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Referral Date: **Patient name:**

Patient DOB: **Patient Phone #:**

Referral Location: **Referring Provider:**

Provider Phone #: **Provider Fax #:**

Involved Eyes: (please circle) **OD** **OS** **OU**

Current Refraction:		**DVA**	**NVA**	**IOP**
OD:	**x**	**20/**	**20/**	**OD:**
OS:	**x**	**20/**	**20/**	**OS:**

Comanagement Care: (please pick one)

☐ Patient prefers to do post op co-management care with WEBB EYECARE

☐ Patient prefers to do post op co-management care with their referring provider

Please attach most recent exam

Please EMAIL or FAX this form to: alliancestaff@webbeyecare.com or 308.762.6652