CONSULTATION FORM
ATTN: SURGERY SCHEDULING
☎ 414.977.3375
414.272.3932

MILWAUKEE EYE CARE
EST. 1933

IF YOUR REFERRAL IS URGENT, PLEASE CALL 414-271-2020 AND ASK TO SPEAK WITH OUR TRIAGE DEPARTMENT

○ **BROOKFIELD**
17280 W North Ave
Suite 100
Brookfield, WI 53045

○ **FRANKLIN**
7095 S Ballpark Dr
Suite 210
Franklin, WI 53132

○ **EAST SIDE**
1684 N Prospect Ave
Milwaukee, WI 53202

○ **BAYSIDE**
8909 N Port Washington Rd
Suite 102
Bayside, WI 53217

○ Jason N. Edmonds, MD ○ Nicholas J. Frame, MD ○ Mackenzie M. Sward, MD

Consulting Doctor: _____ **Phone:** _____

Patient Name: _____ DOB: _____

Patient Home/Cell #: _____ Work: _____

This patient was seen @ the referral office on: _____

Diagnosis: _____ Eye: _____

BCVA: OD 20/_____ OS 20/_____

Most Recent Refraction:

OD _____

OS _____

Add: _____

Milwaukee Eye Care requests that you include a copy of your last chart notes with this consultation form. Our staff will call your patient at the phone number(s) listed above to schedule an evaluation.
Glaucoma Referrals: please fax copies of visual fields and OCTs, if available.

How soon would you like the patient to be seen?
○ Immediately ○ Within one week
○ First available ○ Patient preference

Testing Only Appointment (*indicate requested tests*)
○ HVF ○ Topography
○ OCT ○ Pachymetry

Comments:

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