



OCULOPLASTICS CONSULTATION FORM
ATTN: SURGERY SCHEDULING

 414.977.3375
 414.272.3932

○ *Michael Murphy, M.D.*

○ **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

Referral Information

Consulting Doctor: _____ **Phone:** _____

Patient Name: _____ **DOB:** _____

Patient Phone: _____

Diagnosis: _____ **Eye(s):** _____

Last Date of Service: _____

Services Needed

- | | | | | |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------|---------------------------------|----------------------------------------------|
| <input type="checkbox"/> Upper Eyelid
Blepharoplasty
- functional | <input type="checkbox"/> Upper Eyelid
Blepharoplasty
- cosmetic | <input type="checkbox"/> Lower Eyelid
Blepharoplasty | <input type="checkbox"/> Ptosis | <input type="checkbox"/> Ectropion/Entropion |
| <input type="checkbox"/> Eyelid Lesion | <input type="checkbox"/> Trichiasis | <input type="checkbox"/> Tearing/Lacrimal
Disorders | <input type="checkbox"/> Botox | <input type="checkbox"/> Other |

BCVA: OD 20/_____ OS 20/_____

Comments:

Milwaukee Eye Care requests that you include a copy of your last visit note with this consultation form. Our staff will call this patient at the phone number(s) listed above to schedule an evaluation.