St. Luke's at The Villages
Life Changing Vision®

Cataract Evaluation Referral

PLEASE FAX TO: 352-626-1395

1050 Old Camp Road, Bldg #230, The Villages, FL 32162 • local: 352-350-8484
2955 Brownwood Blvd. Suite 303, The Villages, FL 32163 • local: 352-626-1450

Please complete this form thoroughly to comply with St. Luke's at The Villages co-management requirements.

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

Address (if multiple):_____ Date of Birth: _____

Patient's Name:_____Phone: (_____)_____
First Name Last Name

Referring to: ☐ Kimberly Ireland, MD ☐ Joseph Licht, DO

PERTINENT PATIENT HISTORY:
Ocular Medications: _____
Dominant Eye:_____ Mono CL Wearer: Distance Eye _____ Near Eye _____ Multifocal CL:_____

	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_____

	RIGHT EYE	**LEFT EYE**
Preoperative Findings:		
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.**

Recommendation/recommended target: _____

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

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