ALASKA LASIK & CATARACT CENTER
THE BEST IN SIGHT

Fax to 907-569-1564 or mail to:
Alaska Lasik and Cataract Center
235 E. 8th Ave., Suite 3A
Anchorage, AK 99501

Consultation Request

Referring Doctor

Name______________________________
Phone (___) ________________________
Date of Exam________________________

Patient Information

Name______________________________
Phone (___) ________________________
Date of Birth________________________

Reason for consultation □ OD □ OS □ OU

□ Cataract evaluation □ YAG laser evaluation □ Other____________________________

For cataract evaluation, please provide:

Recommended refractive error outcome: OD__________ OS__________

IOL preference: □ Undetermined □ Multifocal
□ Single-focus
□ Toric

Corneal stability: □ Soft lens wearer □ RGP lens wearer □ Glasses wearer only
□ Advised to leave contacts out ____ weeks before ALCC exam

Clinical Findings	**OD**	**OS**
Dominant Eye	☐	☐
Refraction	______-______x______ 20/___	______-______x______ 20/___
IOP: □ Air □ Applanation □ Other	______mm Hg	______mm Hg

Relevant exam findings ____
____
____

Recommendation to patient ____
____
____

Appointment

□ I have scheduled this patient to be seen at ALCC on: (date)______________ at (time)______________

□ I would like ALCC to phone this patient to schedule an appointment.

Signed______________________________
Referring Doctor