Phone: (913) 897-9299 | Email: SEE@stileseye.com

STILES EYECARE EXCELLENCE
EYECARE PARTNERS.

Patient Consultation Form: ☐ 1st Available

☐ Michael C. Stiles, M.D. ☐ Amanda R. Strom, O.D.
☐ Ann C. Stechschulte, M.D. ☐ Corey Waldman, M.D.

Referring Doctor: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

Patient Name / Date of Birth: _____

Address: _____

City, State, Zip _____

Phone: _____

Needs to be seen within _____ Days, Weeks, Months

Primary Insurance _____ Secondary Insurance _____

Reason for Consultation: (please check all that apply)

☐ Cataract Evaluation
☐ Complete Glaucoma Evaluation
☐ Visual Field Testing (Technical part only)*
☐ Optic Nerve Scan (Technical part only)*
☐ Pachymetry*
☐ I would like to Co-Manage this patient
☐ Evaluation for YAG Capsulotomy
☐ Evaluation for Narrow Angle
☐ Visual Field with Interpretation*
☐ Optic Nerve Scan with Interpretation*
☐ SLT Evaluation
☐ Other:

Pertinent Patient Information: (Please fax or email patient record to 913-897-3031/see@stileseye.com)

Best Correct Visual Acuity: OD_____OS_____ Tonometry: OD: _____ OS: _____

Manifest Refraction: OD: _____

OS: _____ Pachs: OD: _____ OS: _____

Diagnosis & Notes: _____

_____

_____

*Indicates the requesting doctor maintains responsibility of patient's ongoing ophthalmic care.

***Please fax or email this completed consultation form and copy of the patient's most recent eye examination, including all relevant test results, to Stiles Eyecare Excellence (SEE). Fax: 913-897-3031 | Email: see@stileseye.com.**