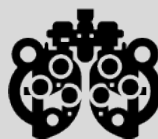


CONSULTATION FORM
ATTN: SURGERY SCHEDULING



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**

9200 W. Loomis Rd.
Suite 204
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 ☐ Peter S. Foote, 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:

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

OD _____

OS _____

Add: _____

How soon would you like the patient to be seen?

- ☐ Immediately ☐ Within one week
☐ First available ☐ Patient preference

Comments:
