CONSULTATION FORM
ATTN: SURGERY SCHEDULING

☎ 414.977.3375
414.272.3932

MILWAUKEE EYE CARE
EST. 1933

○ **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**
500 W. Brown Deer Rd.
Suite 110
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/_____

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.

Most Recent Refraction:

OD _____

OS _____

Add: _____

Comments:

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