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David W. Blodgett, M.D.
Thomas J.E. Clark, M.D.
Samuel L. Thomsen, M.D.
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Pre-Op Co-Management Exam and Request for Consultation

Patient's Name _____ DOB _____ Patient's Phone _____

Requested Consultant: (PLEASE CIRCLE THE DOCTOR YOU REQUEST FOR CONSULTATION)

G.Sutton / V.Sutton / Graul / Sauberan / Wood / Chruscicki / Rixen / Blodgett / Clark / Thomsen

TYPE OF CONSULTATION: (PLEASE MARK BOX)

- Consult and render opinion only.
- Cataract Consult and I have reviewed refractive lens options; my patient would like to look into:
(Please circle one) Monofocal IOL / Toric IOL / Multifocal IOL
*This patient has trialed monovision with contacts? Yes / No
- Consult and then initiate co-management of this patient with me.
- Consult and manage this temporary problem, then return patient to me when resolved.
- I am referring this patient to you for management. I will continue to provide this patient's routine eye care and spectacle needs.
- Other _____

REASON FOR CONSULTATION:

- _____
- Visual fields or other tests have been done in my office and I will forward them to ESA
***TO ASSIST OUR DOCTORS,
PLEASE FORWARD YOUR EXAM NOTES, PHOTOS AND TESTING WITH THIS FORM***

- This patient has been instructed to contact Eye Surgical Associates (ESA) for an appointment.
- Please call patient to schedule an appointment. Pts. Phone # _____
- My office has arranged an ESA appointment for this patient on _____

Please report findings to me by: Mail
 Phone # _____
 Fax # _____

Referring Doctor's Name _____ Date: _____

Practice Address _____

1710 South 70th Street, Lincoln, Ne 68506
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www.esa-neb.com