



Talley Eye Care Associates, P.C.

Fax: (812)-424-3000 Evansville, IN

From _____ Date _____

To: T.W. Talley G. Grant G. John T. Brummer D. Sommerville

Patient _____ D.O.B. _____

Phone: _____ Office Phone _____

Address _____

Consult Request

Cataract

Retina

LASIK

Other

Request LASIK info

Call Patient

Send Lit.

Current RX OD _____ Manifest OD _____

OS _____ OS _____

ADD _____ \bar{S} /OD _____ \bar{C} /OD _____

OS _____ OS _____

*Cycloplegic OD _____ 20/ _____ T<

OS _____ 20/ _____

Reason for Request: _____

Additional Information: _____

* (Cyclo with 1% Cyclogel is Needed for Lasik Consults)