Associated Eye Surgeons

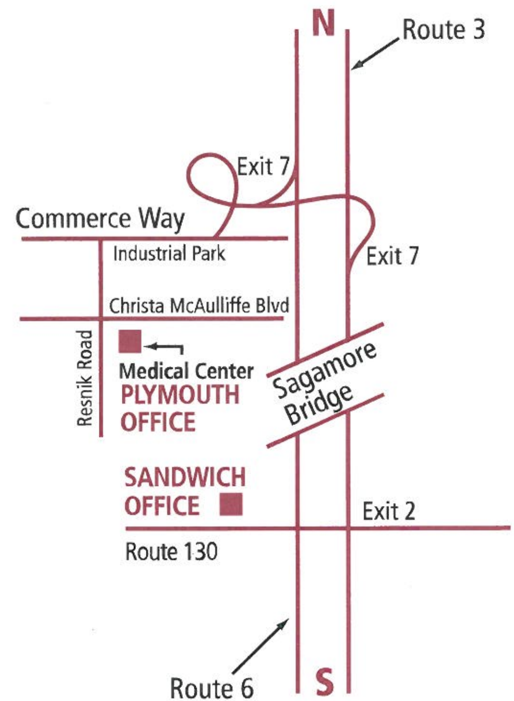
Dear
- ❑ **Dr. Kriegstein**
- ❑ **Dr. Townshend**

I am requesting a consultation for:______________________________ Date of Birth:____________

Patient's telephone number:____

Patient is being sent to your office for:

- ❑ Cataract Evaluation
- ❑ Retinal Evaluation
  - ◯ Macular Degeneration
  - ◯ Diabetes
  - ◯ Other:____________________
- ❑ Premium Intraocular Lens Consultation (Crystalens, Toric)
- ❑ Botox Consultation (Strabismus, Facial Spasm, Migraine)
- ❑ Refractive Surgery (iLasik, PRK, Lasek)
- ❑ Cosmetic Eyelid Surgery (Blepharoplasty)
- ❑ Non-cosmetic Eyelid Surgery and Repair (Skin Cancer)
- ❑ Strabismus
- ❑ Lacrimal System Evaluation
- ❑ Glaucoma
- ❑ Other:____



Doctor requesting consultation (please print)______________________________

May FAX completed form.

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