



Patient Referral for Ophthalmic Evaluation

Referring Provider _____

Date _____

Referring Provider Phone _____

Fax _____

Patient Name _____

DOB _____

Patient Phone _____

Urgency: Urgent (<24 hour) First available Other:

Reason for Referral (check all that apply):

OD OS OU

Glaucoma:

Open Angle Suspect Uncontrolled POAG Angle Closure Suspect Acute Closure

Cataracts

Posterior Capsular Opacification

Foreign Body

Uveitis

Bacterial Keratitis/Ulcer

Keratopathy, Other

Dermatochalasis/Ptosis

Eyelid Lesions/Chalazion

Retinal/Vitreous Hemorrhage

Retina Tear/Detachment

Macular degeneration

Diabetic Retinopathy

Macular Edema

Retinal Vein Occlusion

Optic Neuropathy

Other/Specify: _____

Testing to be included in our correspondence back to you:

Formal Visual Field

Retinal Nerve Fiber Layer OCT

Macular OCT

Anterior Segment OCT

Optical Biometry

Sensorimotor Exam

Dynamic Gonioscopy

Scleral Depression Exam

Neuroimaging

Other/Specify: _____

Requested Treatment (if any): _____

Pertinent Exam Findings (if any): _____



Please include any other pertinent records and testing results if applicable.
For a printable copy of this referral form please visit our website.