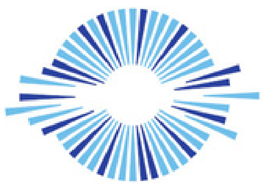

SEQUOIA EYE GROUP

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Patient Referral for Ophthalmic Evaluation

Referring Provider ______________________________ Date ____________________

Referring Provider Phone ______________________________ Fax ____________________

Patient Name ______________________________ DOB ____________________

Patient Phone ______________________________

Urgency: ☐ **Urgent (<24 hour)** ☐ **First available** ☐ **Routine**

Reason for Referral (check all that apply):
☐ **OD** ☐ **OS** ☐ **OU**

Cornea/Refractive/Comprehensive:

☐ Cataracts
☐ Refractive (LASIK/PRK/ICL)
☐ Dry Eye Syndrome
☐ Keratoconus/Corneal Ectasia
☐ Dermatochalasis/Ptosis
☐ Macular Edema
☐ Posterior Capsular Opacification
☐ Bacterial Keratitis/Ulcer
☐ Eyelid Lesions/Chalazion
☐ Macular degeneration
☐ Retinal Vein Occlusion
☐ Retina Tear/Detachment
☐ Corneal Foreign Body
☐ Uveitis
☐ Retinal/Vitreous Hemorrhage
☐ Diabetic Retinopathy
☐ Optic Neuropathy

Glaucoma:

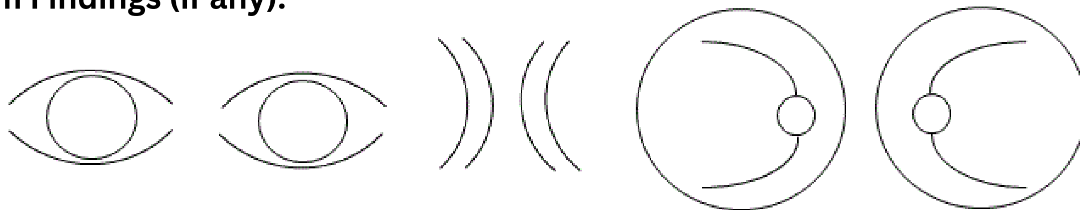
☐ Open Angle Suspect
☐ Angle Closure Suspect
☐ Ocular Hypertension
☐ Stable POAG
☐ Acute Angle Closure
☐ Other glaucoma:
☐ Unstable POAG
☐ Chronic Angle Closure

Other (Specify):

Testing to be included in our correspondence back to you:

☐ Formal Visual Field
☐ Anterior Segment OCT
☐ Dynamic Gonioscopy
☐ B-Scan
☐ Other Testing/Diagnostics (Specify):
☐ Retinal Nerve Fiber Layer OCT
☐ Optical Biometry
☐ Scleral Depression Exam
☐ Macular OCT
☐ Sensorimotor Exam
☐ Neuroimaging

Requested Treatment (if any): ______________________________
Pertinent Exam Findings (if any):



Please include any other pertinent records and testing results if applicable.

Please send completed form via email or fax
For a downloadable form, please visit our website. Thank You!