



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:

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

Glaucoma:

- | | | |
|--|--|--|
| <input type="checkbox"/> Open Angle Suspect | <input type="checkbox"/> Stable POAG | <input type="checkbox"/> Unstable POAG |
| <input type="checkbox"/> Angle Closure Suspect | <input type="checkbox"/> Acute Angle Closure | <input type="checkbox"/> Chronic Angle Closure |
| <input type="checkbox"/> Ocular Hypertension | <input type="checkbox"/> Other glaucoma: | |

Other (Specify):

Testing to be included in our correspondence back to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Formal Visual Field | <input type="checkbox"/> Retinal Nerve Fiber Layer OCT | <input type="checkbox"/> Macular OCT |
| <input type="checkbox"/> Anterior Segment OCT | <input type="checkbox"/> Optical Biometry | <input type="checkbox"/> Sensorimotor Exam |
| <input type="checkbox"/> Dynamic Gonioscopy | <input type="checkbox"/> Scleral Depression Exam | <input type="checkbox"/> Neuroimaging |
| <input type="checkbox"/> B-Scan | | |
| <input type="checkbox"/> Other Testing/Diagnostics (Specify): | | |

Requested Treatment (if any): _____

Pertinent Exam Findings (if any):



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