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REFERRAL FORM

REFERRING DOCTOR:_____ DATE:_____/_____/_____

PATIENT'S NAME:_____ D.O.B._____/_____/_____

HOME PHONE:_____ CELL:_____

ADDRESS:_____CITY:_____ ZIP CODE:_____

E-MAIL ADDRESS:_____

PATIENT APPOINTMENT DATE & TIME:_____

REASON FOR REFERRAL:

□ CATARACT □ DIABETIC RETINOPATHY □ GLAUCOMA
□ LASIK □ LIDS □ MACULAR DEGENERATION
□ PTERYGIUM □ OTHER_____

VA: OD 20/___ cc
OS 20/___ cc

IOP: OD ___
OS ___