BERG·FEINFIELD
VISION CORRECTION

BFVC Location
❒Sherman Oaks ❒Burbank ❒ Arcadia ❒Beverly Hills

Medical Consultation Referral Form

Last Name:_____ First Name:_____ Todays Date: _____

Gender: _____ Date of Birth: _____/_____/_____ Phone (_____)_____ ❒Mobile ❒Home

Street Address: _____City: _____State: _____ Zip:_____

Email: _____ Medical Insurance: _____
❒Medicare ❒PPO ❒HMO (Facey/Axminster)

Procedure Discussed: ❒OU / ❒OD / ❒OS

❒Cataract ❒Glaucoma ❒Eyelid Surgery ❒Pterygium ❒Chalazion ❒Strabismus ❒Corneal Diseases

❒Diabetes ❒Aesthetics (Botox/Restylane/Juvederm/Latisse) ❒Pediatric ❒Other:_____

Comments: _____

Referring Doctor: _____ **Office Location**_____ ***(city only)***

OD Phone: (_____) _____ **OD Fax: (_____)** _____

OD: Email: _____

Examination

Ocular History: _____

Medical History: _____

OD		***OS***
_____	Uncorrected Visual Acuity	_____
_____20/____	Current Spectacles	_____20/____
_____20/___ Add:____	Manifest Refraction	_____20/___ Add:____
_____20/____	1% Mydriacyl Refraction (or 1% Tropicamide)	_____20/____
_____	Keratometry	_____
_____	Tonometry *(if available)*	_____
_____	IOP	_____

Dominant Eye: _____

_____	Lids / Lashes / Lacrimal	_____
_____	Conjunctiva	_____
_____	Cornea	_____
_____	Anterior Chamber	_____
_____	Iris	_____
_____	Lens	_____
C/D_____ Macula_____	Dilated Fundus Exam	C/D_____ Macula_____
_____	Periphery	_____

Doctor's Signature:_____ Exam Date:_____

FAX TO 818.845.6614 or EMAIL TO info@bergfeinfield.com

FOR OFFICE USE ONLY: LASIK Consult Scheduled _____/_____/_____ @ Sherman Oaks / Burbank / Arcadia / Beverly Hills

Initial Call _____/_____/_____ Faxed to OD _____/_____/_____ _____ (initials)

❒Left message ❒Spoke to patient, will check schedule and call back ❒Not interested at this time, follow-up in ____ weeks / months

_____