Consultation Office Location: ***(please check one)***

13320 Riverside Dr., Ste. 114 Sherman Oaks, CA 91423 Phone: 818-501-3937 Fax: 818-980-0651	2625 W. Alameda Ave., Ste. 208 Burbank, CA 91505 Phone: 818-980-2020 Fax: 818-845-1916	1936 Huntington Dr., Ste. A South Pasadena, CA 91030 Phone: 626-795-9793 Fax: 818-845-1916	9100 Wilshire Blvd., Suite 852W Beverly Hills, CA 90212 Phone: 866-273-3327 Fax: 818-845-1916

Medical Consultation Referral Form

Today's Date Legal Last name:_________________________ Legal First name:_______________________

___/___/___ aka ___________________________ Male/Female Date of Birth: _____/_____/_____

Home/Daytime Phone (____)________________Mobile Phone (____)________________Best # to call: ________

Street Address: ___________________________________City: _______________State: _____ Zip:__________

Reasons for considering surgery/expectations/comments: ____

____

Procedure/Treatment Discussed: **OU / OD / OS**

❒Cataract ❒Glaucoma ❒Eyelid Surgery ❒Pterygium ❒Chalazion ❒Strabismus ❒Corneal Diseases
❒Diabetic Retinopathy ❒Aesthetics (Botox/Restylane/Juvederm/Latisse ❒Other:______________________

❒ Cash ❒ Insurance *(provide below)* ❒ HMO ❒ PPO
Insurance carrier:______________________________
(Company Name)

Do we need to contact patient regarding appointment? ❒ Yes ❒ No
Is patient interested in 0% financing? ❒ Yes ❒ No

Referring Doctor: ___________________________Office Location________________________
(city only)

O.D. Phone: (____) ___________________ **Fax:** (____) ______________________

Ocular History:____
Medical History:____
Current Medications:____
Allergies:____

Examination

OD **OS**

___________________________ **Uncorrected Visual Acuity** ___________________________

________________________20/____ **Current Spectacles** ________________________20/____

_________________20/___ Add:____ **Manifest Refraction** _________________20/___ Add:____

_________________20/___ Add:____ **Cycloplegic Refraction** _________________20/___ Add:____

(only if completed, otherwise can be performed at a later date)

______________________________ **Keratometry** ______________________________

______________________________ **Tonometry** ______________________________
(if available)

Dominant Eye: ______________

_____________________ **Lids / Lashes / Lacrimal** _____________________

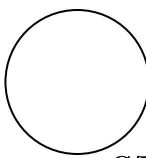
_________________________ **Conjunctiva** _________________________

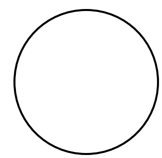
___________________________ **Cornea** ___________________________

______________________ **Anterior Chamber** ______________________

_____________________________ **Iris** _____________________________

_____________________________ **Lens** _____________________________





C/D_______ **Macula**________ **Dilated Fundus Exam** **C/D**_______ **Macula**________

_______________________________ **Periphery** _______________________________

Doctor's Signature:_________________________________Exam Date:___________________

Please fax form back to (818) 845-1916

FOR OFFICE USE ONLY: Medical Consult Scheduled ______/______/______ Sherman Oaks / Burbank / So. Pasadena / Beverly Hills

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

Notes:____

____