



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 _____ 20/____
(or 1% Tropicamide)
_____ 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 818.845.7068 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