



Consultation Office Location: (please check one)

13320 Riverside Dr., Suite 114
Sherman Oaks, CA 91423
Phone: 818-501-3937
Fax: 818-980-0651

2625 W. Alameda Ave., Suite 208
Burbank, CA 91505
Phone: 818-980-2020
Fax: 818-845-1916

1936 Huntington Dr., Suite 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

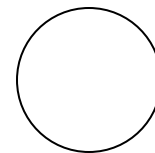
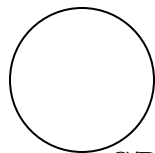
OS

Uncorrected Visual Acuity
Current Spectacles
Manifest Refraction
1% Mydriacyl Refraction (or 1% Tropicamide)

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 to our SURGERY DEPARTMENT office at (818) 845-5205

FOR OFFICE USE ONLY: LASIK Consult Scheduled @ Sherman Oaks / Burbank / So. Pasadena / 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