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

# Refractive Surgery 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 / ❒Monovision

❒Custom ❒IntraLASIK (All Laser) ❒PRK ❒RLE/CLE ❒ICL ❒Crosslinking (Exam fee applies)

**Quoted Price $**________________ with One Year Enhancement Included **$**________________ with Lifetime Commitment

**Referring Doctor:** ______________________________ **Office Location**____________________ ***(city only)***

**OD Phone: (_______)** ____________________ **OD Fax: (_______)** _______________________

**OD: Email:** ________________________________________________________

## Examination

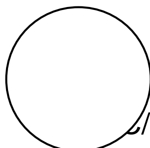
Has patient had previous eye surgery? ❒Yes ❒No If Yes, there will be an applicable exam fee, or we will accept insurance for the visit.

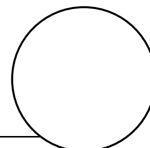
Ocular History: _______________________________________________________________________________

Medical History: ______________________________________________________________________________

Contact Lens History: # of year(s) worn _____ Daily Soft / Soft Toric / Gas Permeable (RGP) *(Please circle one)*

| ***OD*** | | ***OS*** |
|---|---|---|
| _________________________20/_____ | Contact Lens Power OS: | _________________________20/_____ |
| ____________________________ | 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 818.845.1916 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

______________________________________________________________________________________