REFERRING DOCTORS

THANK YOU SO MUCH FOR TRUSTING US WITH YOUR PATIENT!

Please send your notes and complete the following information:

Referring Doctor:

Patient Name *

Patient Phone Number *

Date Of Birth (yyyy-mm-dd)

Appointment has been made with Dr.

Date (yyyy-mm-dd)

Time (hh:mm am/pm)

- [ ] Please call Patient to set Appointment.

Referral Notes

- [ ] Previously Sent
- [ ] Sending Today

Referred for (Check all that apply)

- [ ] Dry Eye Evaluation (with Oculus 5M Keratograph and Crystal Tear Report) and necessary testing/ treatment
- [ ] Tear Lab Osmolarity
- [ ] Inflammadry
- [ ] Punctal Occlusion
- [ ] Blepharoexfoliation: NuLids / BlephEx
- [ ] Intense Pulsed Light (IPL)
- [ ] Lipiscan / Lipiflow
- [ ] External Neurostimulation
- [ ] Prokera Amniotic Membrane
- [ ] Autologous Blood Serum
- [ ] Scleral Lens Fitting
- [ ] Percutaneous Allergy Skin Testing (78 allergans)

Please return patient after:

- [ ] Dry eye evaluation and report, without treatment
- [ ] Dry eye evaluation, report, and treatment initiation
- [ ] Treatment indicated above, without evaluation (not recommended)
- [ ] Once symptoms have resolved and patient is stable
- [ ] For non-ocular surface issues only (routine exam, retina, glaucoma, etc)

Additional notes:

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