Desert Eye and Laser

Vision Correction
Referral Form

Patient First Name

Patient Last Name

Date

Patient Phone Number

Email Address

Referring Doctor

Doctor Location

Reason For Consultation

- ☐ Cararact Evaluation
- ☐ Glaucoma Evaluation
- ☐ Corneal Evaluation
- ☐ Diabetic Retinopathy Evaluation
- ☐ Strabismus/ Amblyopia
- ☐ LASIK Evaluation
- ☐ Wavescan Analysis
- ☐ Orbscan Topography
- ☐ Macular Degeneration
- ☐ Other (please specify):
- ☐ Oculoplastics
- ☐ Blepharoplasty
- ☐ Cosmetic
- ☐ Flashes/ Floaters

Current Clinical Findings

Refraction

OD
OS

BVA

OD
OS

IOP

OD
OS

Time

☐ Non-contact ☐ Applanation

Other Significant Findings:

Procedures Ordered:

A report will be sent to the referring doctor.