BVA BETTER VISION AHEAD. Advanced Eye Care

Patient Referral Form

DATE OF REFERRAL:_____

PATIENT'S NAME:_____ DOB:_____

PATIENT'S PHONE #(_____) _____-_____ Current Medications: (Bring All Medications To Exam)

REFERRING DOCTOR:_____ _____

Appt. Date:_____ Time:_____

Reason for Referral or Consultation:

☐ Cataract ☐ Cornea ☐ Glaucoma ☐ Neuro-ophthal ☐ Refractive Surgery ☐ Ultrasonography

☐ Retina ☐ Diabetes ☐ Macular Degeneration ☐ Visual Field ☐ Photos

☐ OCT ☐ OCT-Macula ☐ OCT-Optic Nerve ☐ Pachymetry ☐ Other_____

Date of last exam: _____ Last IOP_____ OD _____ mmHg OS _____mmHg

(For Glaucoma patients) Last OCT Optic Nerve _____ attached/not attached Last Visual Field_____ attached/not attached

History: _____

_____

Dx: _____

_____

Current Rx: OD _____20/_____ Manifest OD _____20/_____

OS _____20/_____ OS _____20/_____

☐ Please mail results ☐ Please send results with patient

Patient Confirmation

It is my desire to have my own optometrist, Doctor _____ perform my postoperative follow-up care after my cataract/refractive (circle one) surgery.

Patient: _____ Date: _____

Optometrist Confirmation

I have agreed to provide follow-up care for _____. I will see the patient after surgery when Doctor_____notifies me that he has released the patient to my care. I agree to notify Doctor _____ immediately should complications arise and to provide written progress reports regularly during my portion of the postoperative period.

Optometrist: _____ Date: _____

BVA ADVANCED EYE CARE

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