



Dr. Vivian Hill
Eye Physician & Surgeon
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Patient Name: Last _____ First _____ AHC#: _____
 DOB: Mon/ Day/ Year ____/____/____ Gender M / F / O Family Physician: _____
 Email: _____ Cell Phone: _____ Other Phone: _____
 Address: _____
 For Pediatric patients- Mother: _____ Father: _____

Please note: We contact patients directly with the appointment date and time by **email and/or cell phone**.
 If this information is not provided the referral process may be delayed.

Reason for referral:

Strabismus _____
 Neuro-ophth _____
 Optic neuritis or IIH _____
 Amblyopia _____
 Myopia & refraction _____
 Medical Botox _____
 Stye & Pterygium _____
 Cosmetic filler/Botox _____
 Pharmacy Phone Number _____
 Other: _____

History:

Systemic Meds _____
 Allergies _____
 Eye drops Right eye _____
 Eye drops left eye _____
 Emergency Contact _____

Visual Acuity: Right: _____ Left: _____

IOP: Right: _____ Left: _____

Refraction: Right: _____

Left: _____

Notes: _____

Referring Doctor Name:	PRACID:	Office Address Stamp:
Office Phone:	Office Fax:	
Specialty	Date of Referral:	