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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 History**

Cataracts \_\_\_\_\_\_\_\_ 366 IOL or CATC Systemic Meds\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Orbital disease/Graves\_\_\_376 ORBT or ORBC Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ptosis \_\_\_\_\_\_ 374 LIDT or LIDC Eye drops Right eye \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eyelid Malposition\_\_\_\_ 374 LIDC Eye drops Left eye \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tearing \_\_\_\_\_\_\_\_\_ 375 DCRC Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eyelid lesion or Stye \_\_\_\_\_374 STYE Emergency Contact phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Botox \_\_\_\_\_\_\_ 374 MEDB Pharmacy Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cosmetic Eyelid concern \_374 LIDC

Mohs \_\_\_\_\_\_\_\_\_ 172.1 LIDSC

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Visual Acuity:** Right: \_\_\_\_\_\_\_\_\_\_\_Left:\_\_\_\_\_\_\_\_\_\_\_ **IOP:** Right: \_\_\_\_\_\_\_\_ Left:\_\_\_\_\_\_\_\_

**Refraction:** Right:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Left: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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