BETTER VISION AHEAD.
Advanced Eye Care

REFERRAL FORM

Date of Referral:_____

Referring Doctor: _____

PATIENT INFORMATION

Patient Name:_____ DOB:_____

Phone:_____

Email:_____

Insurance:_____

Member ID:_____

Reason for Referral: (Check One)

☐ Cataract ☐ Cornea ☐ Glaucoma

☐ YAG Capsulotomy ☐ Diabetes ☐ Visual Field

☐ OCT – Macula ☐ OCT – Optic Nerve ☐ Dry Eye Evaluation

☐ Other _____

Preferred Surgeon (if surgery required):

☐ First Available ☐ Britton ☐ Carter

☐ Hartman ☐ Mathews ☐ Nguyen

Please include the last exam, testing, and patient's demographics and insurance cards with this referral.

Additional Comments:

_____

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