BVA
BETTER VISION AHEAD.
Advanced Eye Care

Patient Referral Form

DATE OF REFERRAL:_____

PATIENT'S NAME:_____ AGE:_____

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

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: _____

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