

- Dr. Ahmed Al-Ghoul
- Dr. Vikram Lekhi
- Dr. John McWhae
- Dr. Jason Wesolosky
- Dr. Sophia Leung
- Or First Available

Patient Name: _____	DOB: _____	AHC: _____
Address: _____		Telephone: _____
Email: _____		

Reason for Referral:  URGENT       ROUTINE       Right     Left     Both

<b>Eye lids / Orbit</b>			
<input type="checkbox"/> Lesion Removal	<input type="checkbox"/> Droopy Lids	<input type="checkbox"/> Botox	<input type="checkbox"/> Blepharospasm
<b>Cornea / Conjunctiva</b>			
<input type="checkbox"/> Keratoconus/CXL	<input type="checkbox"/> Dry Eye	<input type="checkbox"/> Transplant	<input type="checkbox"/> Pterygium
<input type="checkbox"/> Infection	<input type="checkbox"/> Corneal Erosion	<input type="checkbox"/> PTK	<input type="checkbox"/> Other
<b>Cataracts</b>			
<input type="checkbox"/> Yag Laser	<input type="checkbox"/> Cataract Surgery	<input type="checkbox"/> Lens Issue	<input type="checkbox"/> Secondary IOL Repair
<b>Glaucoma</b>			
<input type="checkbox"/> Narrow Angle	<input type="checkbox"/> Medical Treatment	<input type="checkbox"/> Laser Treatment	
<b>Uveitis</b>			
<input type="checkbox"/> Anterior	<input type="checkbox"/> Posterior		
<b>Retina Screening</b>			
<input type="checkbox"/> Retinal Tear	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Myopia	<input type="checkbox"/> Other

<b>Screening:</b>			
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Flashes/Floaters
<input type="checkbox"/> Dry Eye	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Nevus Screening	<input type="checkbox"/> Autoimmune Disease
<input type="checkbox"/> Diplopia	<input type="checkbox"/> Vision Loss	<input type="checkbox"/> Medication / Plaquenil / Aminoderone	

Comments:

Referring Doctor:     OD     GP     ER     Internal Medicine     Ophthalmologist     Other

Doctor Name:	Prac ID:
Office Phone :	Office Fax:
Date of Referral:	Clinic Name: