SEQUOIA EYE GROUP

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Patient Referral for Ophthalmic Evaluation

Referring Provider _____ Date_____

Referring Provider Phone _____ Fax _____

Patient Name _____ DOB _____

Patient Phone _____

Urgency: ☐ Urgent (<24 hour) ☐ First available ☐ Other:

Reason for Referral (check all that apply):
☐ OD ☐ OS ☐ OU

Glaucoma:
☐ Open Angle Suspect ☐ Uncontrolled POAG ☐ Angle Closure Suspect ☐ Acute Closure

☐ Cataracts	**☐ Posterior Capsular Opacification**	**☐ Foreign Body**
☐ Uveitis	**☐ Bacterial Keratitis/Ulcer**	**☐ Keratopathy, Other**
☐ Dermatochalasis/Ptosis	**☐ Eyelid Lesions/Chalazion**	**☐ Retinal/Vitreous Hemorrhage**
☐ Retina Tear/Detachment	**☐ Macular degeneration**	**☐ Diabetic Retinopathy**
☐ Macular Edema	**☐ Retinal Vein Occlusion**	**☐ Optic Neuropathy**

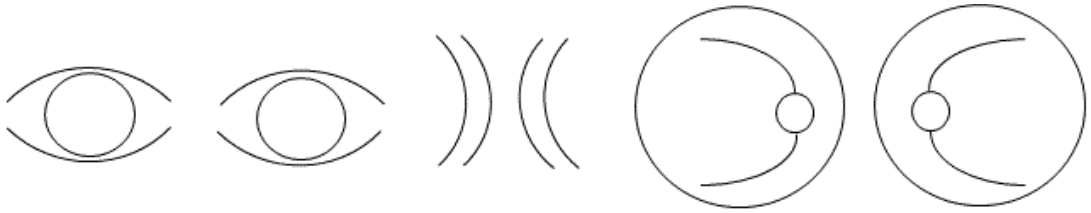
Other/Specify:

Testing to be included in our correspondence back to you:

☐ Formal Visual Field	**☐ Retinal Nerve Fiber Layer OCT**	**☐ Macular OCT**
☐ Anterior Segment OCT	**☐ Optical Biometry**	**☐ Sensorimotor Exam**
☐ Dynamic Gonioscopy	**☐ Scleral Depression Exam**	**☐ Neuroimaging**

Other/Specify:

Requested Treatment (if any): _____
Pertinent Exam Findings (if any):



Please include any other pertinent records and testing results if applicable.
For a printable copy of this referral form please visit our website.

Please Fax Form to: 650-369-5400. Thank You!