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 □ Routine

Reason for Referral (check all that apply):

□ OD □ OS □ OU

Cornea/Refractive/Comprehensive:

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

Glaucoma:

□ Open Angle Suspect
□ Angle Closure Suspect
□ Ocular Hypertension
□ Stable POAG
□ Acute Angle Closure
□ Other glaucoma:
□ Unstable POAG
□ Chronic Angle Closure

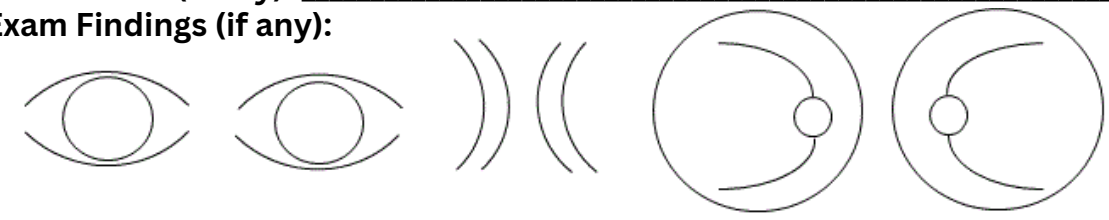
Other (Specify):

Testing to be included in our correspondence back to you:

□ Formal Visual Field
□ Anterior Segment OCT
□ Dynamic Gonioscopy
□ B-Scan
□ Retinal Nerve Fiber Layer OCT
□ Optical Biometry
□ Scleral Depression Exam
□ Macular OCT
□ Sensorimotor Exam
□ Neuroimaging
□ Other Testing/Diagnostics (Specify):

Requested Treatment (if any): _____

Pertinent Exam Findings (if any):



Please include any other pertinent records and testing results if applicable.

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