SEQUOIA EYE GROUP

162 Clinton Street, Redwood City, CA 94062
Phone (650) 839-2020 Fax (650) 369-5400
reception@sequoiaeyegroup.com sequoiaeyegroup.com

Patient Referral for Ophthalmic Evaluation

Complete on your computer or print. Fax to (650) 369-5400, or refer online at sequoiaeyegroup.com/patient-referral-forms

REFERRING PROVIDER

Referring provider

Practice or clinic

Provider phone

Fax

Email for our reply

PATIENT

Patient name

Date of birth (MM/DD/YYYY)

Referral date

Patient phone

Insurance (if known)

URGENCY AND EYE

Urgency ☐ Urgent (within 24 hours) ☐ First available ☐ Routine **Eye** ☐ OD ☐ OS ☐ OU

REASON FOR REFERRAL (CHECK ALL THAT APPLY)

Glaucoma

☐ Open Angle Suspect ☐ Stable POAG ☐ Unstable POAG
☐ Angle Closure Suspect ☐ Acute Angle Closure ☐ Chronic Angle Closure
☐ Ocular Hypertension

Other glaucoma (specify):

Refractive

☐ Refractive cataract surgery and premium lens implants ☐ Astigmatism correction (toric lens)
☐ Presbyopia correcting lens (multifocal or extended depth of focus) ☐ Clear lens exchange

Other refractive (specify):

Cornea and comprehensive

☐ Cataracts ☐ Posterior Capsular Opacification ☐ Corneal 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 cornea or comprehensive (specify):

REQUESTED TESTING

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

Other testing or diagnostics (specify):

CLINICAL DETAILS

Requested treatment (if any)

Pertinent exam findings and notes (if any)