Laser and Corneal Surgery Associates, P.C.

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REFERRAL FOR EVALUATION AND CONSULTATION

Referring Doctor: ______________________ Date: ____________
Phone: ______________________

Patient:	____________________	DOB:	____________________
Address:	____________________		
City, State:	____________________	Zip:	____________________
Phone:		E-mail:	

UCVA	Manifest Refraction or Current Spectacle Rx	
OD: 20/	**OD:**	**20/**
OS: 20/	**OS:**	**20/**

Recommendation:

- ☐ Corneal Crosslinking
- ☐ Cataract Surgery
- ☐ Penetrating Keratoplasty
- ☐ Endothelial Keratoplasty (DSEK or DMEK)
- ☐ Other:
- ☐ LASIK or PRK
- ☐ Clear Lens Exchange
- ☐ ICL (Phakic IOL)
- ☐ Pterygium Removal
- ☐ YAG Capsulotomy

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- ☐ Please contact patient to schedule an evaluation and consultation.
- ☐ Comment: ____

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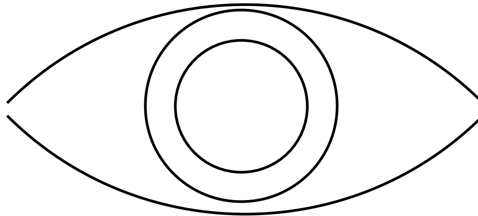

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