CALIFORNIA
Eye Surgeons

OPHTHALMOLOGY SURGERY REFERRAL FORM

Patient Name: _____

Date of Birth: _____

Patient Phone: _____

Insurance: _____

INDICATION FOR CONSULT:

☐ Cataract Surgery

☐ Glaucoma Laser / Glaucoma Consult

☐ Dry Eyes / Lipiflow

☐ Pterygium Surgery

☐ Other/Comments: _____

_____

_____

_____

_____

_____

Doctor Requesting Consult: _____

Requesting Doctor's Tel #: _____ Fax #: _____

Report should be: ☐ Faxed ☐ Mailed

Putting Patient Care First

California Eye Surgeons • www.CalEyes.com

555 Knowles Drive, Suite 117 • **LOS GATOS, CA** 95032 • Tel: 408-940-3930 • Fax: 408-940-3945
7652 Monterey Street, Suite B • **GILROY, CA** 95020 • Tel: 408-842-2500 • Fax: 408-940-3945

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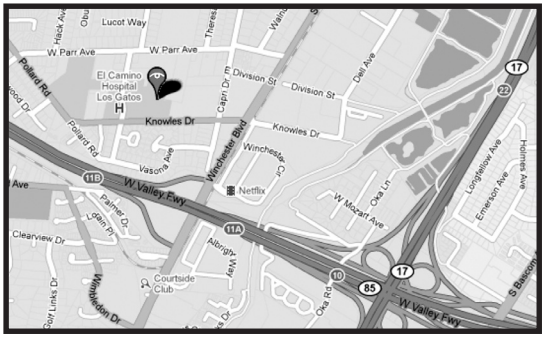
To the patient: Please bring this form with you to your appointment.
Please notify us within 48 hours if you are unable to keep your appointment.

Your appointment with California Eye Surgeons has been set for:

Date: _____ Time: _____



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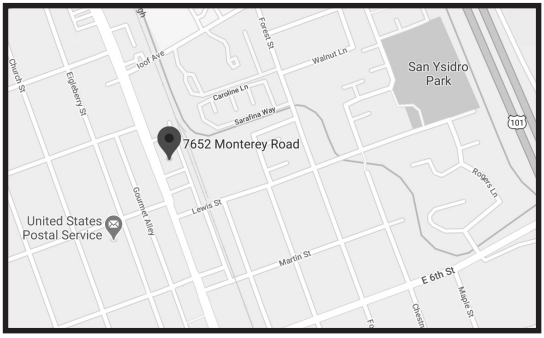

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