ADV Vision MD Referral Form

ADV VISION

Date: _____

Patient Name: _____ Patient Phone: _____

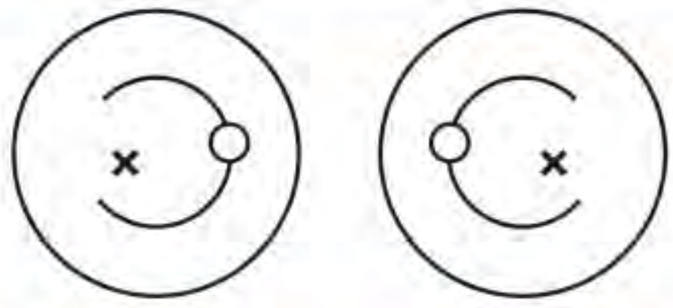
Patient DOB: _____ Date of Appointment: _____ Time: _____

Referring Physician: _____

Phone: _____ Fax: _____ Insurance: _____

If the patient has a HMO and this is the first time at our office, an authorization from the patient's PCP will be needed before they can be be seen.

BRIEFLY STATE THE REASON FOR THE REFERRAL



DIAGNOSIS

- ☐ General Opthalmology
- ☐ Cataracts
- ☐ Blepharoplasty
- ☐ Eye Exam
- ☐ Macular Degeneration
- ☐ Red Eye
- ☐ Diabetic Retinopathy
- ☐ Pterygium
- ☐ Strabismus
- ☐ YAG
- ☐ Blurry Vision
- ☐ Glaucoma Screening
- ☐ Other:

REQUESTED APPT. TIMEFRAME

- ☐ Immediately (Please call us directly)
- ☐ Within one week
- ☐ Within one month
- ☐ When patient prefers
- ☐ Other: _____

OFFICE REQUESTED

- ☐ **Paso Robles**
  104 Gateway Center
  Suite B
  Paso Robles, CA 93446
- ☐ **San Luis Obispo**
  835 Aerovista Lane
  #110
  San Luis Obispo, CA 93401
- ☐ **Santa Maria**
  821 E. Chapel Street
  Santa Maria, CA 93454

Submit Referral Via:
Phone: (805) 987-5300
Fax: (818) 707-7668
Email: info@doughertylaservision.com

Upon receipt, we will contact your patient within one business day to schedule the requested appointment. We will also contact your office to inform you of the upcoming appointment date/time. Please provide your contact information if you would like us to notify you specifically.

Name: _____ Phone: _____

THANK YOU FOR YOUR REFERRAL

ADV Vision OD Referral Form

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Phone: _____ Fax: _____ Insurance: _____

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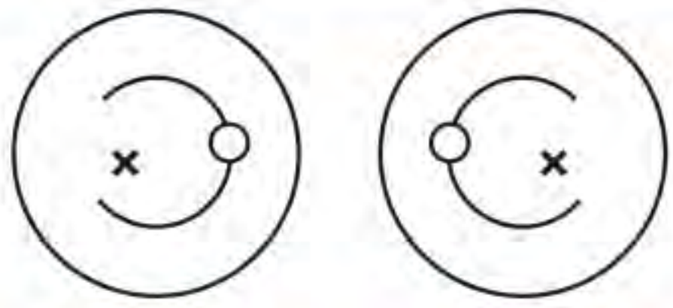

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