REFERRAL FORM

DLV VISION

_____/_____/_____
DATE

_____
PATIENT NAME

(_____)_____-_____
PATIENT PHONE

_____/_____/_____
PATIENT DOB

_____
PATIENT EMAIL

_____
REFERRING PHYSICIAN

_____
INSURANCE

(_____)_____-_____
PHONE

If the patient has an HMO and this is their first time at our office, an authorization from the patient's PCP will be needed before they can be seen. Please send a copy of patient's insurance cards and last appointment notes.

(_____)_____-_____
FAX

BRIEFLY STATE THE REASON FOR THE REFERRAL

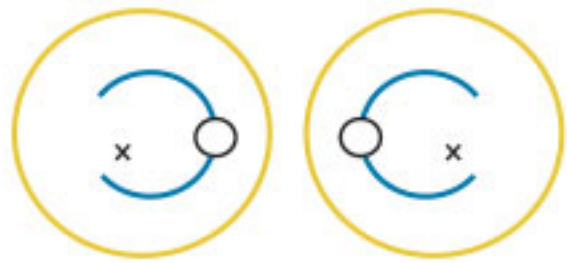
NOTES *Please attach MR, it will save patients 20 min in their appointment.*

_____

_____

_____

_____



DIAGNOSIS

- ❍ **LASIK** *(-1.00 to -8.00)*
- ❍ **Cataract** *(20/30+Bat)*
- ❍ **ICL** *(-3.00 to -25.00)*
- ❍ **RLE** *(20/30+Bat)*
- ❍ **YAG/PCO** *(post 90 days)*
- ❍ **CORNEAL CXL**
- ❍ **Intacs**
- ❍ **Enhancement Surgery**
- ❍ **Glaucoma**
- ❍ **General Ophthalmology**
- ❍ **Botox/Juvederm**
- ❍ **Laser Skin Resurfacing**
- ❍ **Other** _____

We had cataract discussion

- ❍ **Laser Assisted**
- ❍ **Premium Lens Package**
- ❍ **Economy Lens Package**
- ❍ **Basic Lens Option**

APPT TIMEFRAME

- ❍ **Immediately** *(Please call us directly)*
- ❍ **Within one week**
- ❍ **Withinn one month**
- ❍ **When patient prefers**
- ❍ **Other** _____

Preferred Communication

- ❍ **Call**
- ❍ **Text**
- ❍ **Email**
- ❍ **Any of the above**

OFFICE REQUESTED

- ❍ **CAMARILLO**
  1821 E. Daily Drive
  Camarillo, CA 93010
- ❍ **ENCINO**
  16130 Ventura Blvd. #120
  Encino, CA 91436
- ❍ **RESEDA**
  7012 Reseda Blvd., Suite 105
  Reseda, CA 91335
- ❍ **SAN LUIS OBISPO**
  835 Aerovista Lane #110
  San Luis Obispo, CA 93401
- ❍ **SIMI VALLEY**
  2796 Sycamore Drive #101
  Simi Valley, CA 93065
- ❍ **WESTLAKE VILLAGE**
  4353 Park Terrace Drive #150
  Westlake Village, CA 91361

PHYSICIAN


❍ **Paul J. Doughtery, M.D.**


❍ **Asha Balakrishnan, M.D.**


❍ **Houman Vosoghi, M.D.**


❍ **Patrick Pham, M.D.**


❍ **Anh Le, O.D.**


❍ **Sidra Qadri, O.D.**


❍ **Devon Kennedy, O.D.**

_____

❍ **Next Available**

What is one unique thing about this patient (i.e., hobbies, activities, etc.)? _____

_____

Are there any special event(s) in this patient's life coming up? _____

Are there any time constraints? _____

SUBMIT REFERRAL VIA:

PHONE 805-987-5300 **FAX** 818-707-7668 **TEXT**
EMAIL Referrals@DoughertyLaserVision.com