

REFERRAL FORM



DLV VISION

DATE

PATIENT NAME

PATIENT PHONE

PATIENT DOB

PATIENT EMAIL

REFERRING PHYSICIAN

INSURANCE

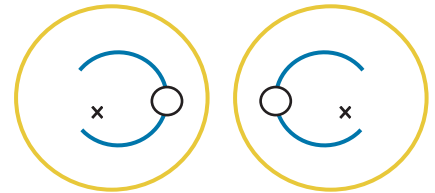
PHONE

FAX

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.

BRIEFLY STATE THE REASON FOR THE REFERRAL

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



DIAGNOSIS	APPT TIMEFRAME	OFFICE REQUESTED	PHYSICIAN
<input type="radio"/> LASIK (-1.00 to -8.00) <input type="radio"/> Cataract (20/30+Bat) <input type="radio"/> ICL (-3.00 to -25.00) <input type="radio"/> RLE (20/30+Bat) <input type="radio"/> YAG/PCO (post 90 days) <input type="radio"/> CORNEAL CXL <input type="radio"/> Intacs <input type="radio"/> Dry Eye/Blepharitis <input type="radio"/> Only LipiFlow <input type="radio"/> Only Intense Pulsed Light (IPL) <input type="radio"/> Only BlephEx <input type="radio"/> Enhancement Surgery <input type="radio"/> Glaucoma <input type="radio"/> General Ophthalmology <input type="radio"/> Botox/Juvederm <input type="radio"/> Laser Skin Resurfacing <input type="radio"/> Posterior Vitreous Detachment <input type="radio"/> Retinal Tear/Hole <input type="radio"/> Lattice Degeneration <input type="radio"/> Retinal Detachment <input type="radio"/> Dry/Wet Macular Degeneration <input type="radio"/> Diabetic Retinopathy <input type="radio"/> Macular Edema <input type="radio"/> Choroidal Nevus/Melanoma <input type="radio"/> Uveitis Eye (OD, OS) <input type="radio"/> Oculoplastic <input type="radio"/> Other	<input type="radio"/> Immediately (Please call us directly) <input type="radio"/> Within one week <input type="radio"/> Within one month <input type="radio"/> When patient prefers <input type="radio"/> Other Preferred Communication <input type="radio"/> Call <input type="radio"/> Text <input type="radio"/> Email <input type="radio"/> Any of the above We had cataract discussion <input type="radio"/> Laser Assisted <input type="radio"/> Premium Lens Package <input type="radio"/> Economy Lens Package <input type="radio"/> Basic Lens Option Glaucoma Referrals <input type="radio"/> Surgical Glaucoma <input type="radio"/> Clinical Ongoing <input type="radio"/> Clinical Annual <input type="radio"/> Clinical One-Time Visit	<input type="radio"/> WESTLAKE VILLAGE 4353 Park Terrace Drive #150 Westlake Village, CA 91361 <input type="radio"/> CAMARILLO 1821 E. Daily Drive Camarillo, CA 93010 <input type="radio"/> ENCINO 16130 Ventura Blvd. #120 Encino, CA 91436 <input type="radio"/> SIMI VALLEY 2796 Sycamore Drive #101 Simi Valley, CA 93065 <input type="radio"/> NEWBURY PARK 1000 Newbury Rd., Ste. 220 Newbury Park, CA 91320 <input type="radio"/> VENTURA 5682 Ventura Blvd., Suite 1 Ventura, CA 93003	<input type="radio"/> Paul J. Dougherty, MD Refractive & Cataract Specialist <input type="radio"/> Asha Balakrishnan, MD Refractive, Cataract, & Cornea Specialist <input type="radio"/> Houman Vosoghi, MD Glaucoma Specialist <input type="radio"/> Xiaolin (Lynn) Zhang, MD Refractive, Dry Eye, & Cataract Specialist <input type="radio"/> Joseph Chen, MD Glaucoma & Cataract Specialist <input type="radio"/> Moisés Enghelberg, DO, MSC Retina Specialist <input type="radio"/> Nicolas Biro, MD Ophthalmologist & Oculoplastic Surgeon <input type="radio"/> Alique Boulgourjian, OD <input type="radio"/> Sidra Qadri, OD <input type="radio"/> Anh Le, OD <input type="radio"/> 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