REFERRAL FORM

____ / ____ / ____
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.*

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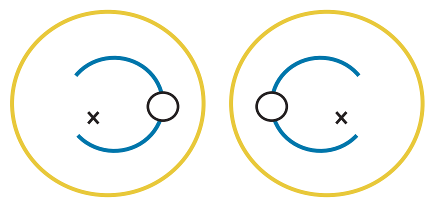

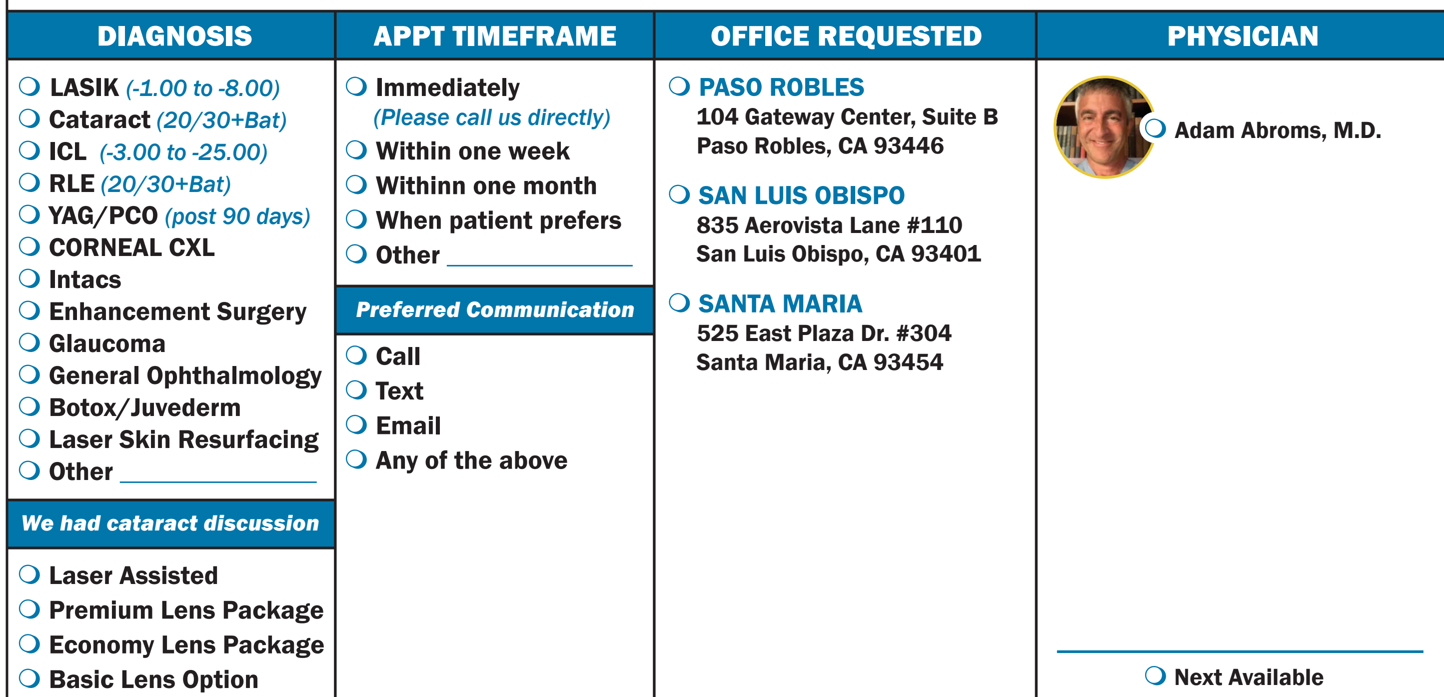

DIAGNOSIS	APPT TIMEFRAME	OFFICE REQUESTED	PHYSICIAN
❍ LASIK *(-1.00 to -8.00)* ❍ Cataract *(20/30+Bat)* ❍ ICL *(-3.00 to -25.00)* ❍ RLE *(20/30+Bat)* ❍ YAG/PCO *(post 90 days)* ❍ CORNEAL CXL ❍ Intacs ❍ Enhancement Surgery ❍ Glaucoma ❍ General Ophthalmology ❍ Botox/Juvederm ❍ Laser Skin Resurfacing ❍ Other ________ ***We had cataract discussion*** ❍ Laser Assisted ❍ Premium Lens Package ❍ Economy Lens Package ❍ Basic Lens Option	❍ Immediately *(Please call us directly)* ❍ Within one week ❍ Withinn one month ❍ When patient prefers ❍ Other ________ ***Preferred Communication*** ❍ Call ❍ Text ❍ Email ❍ Any of the above	❍ **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** 525 East Plaza Dr. #304 Santa Maria, CA 93454	❍ Adam Abroms, M.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 805-621-7737 TEXT
EMAIL Info@ADVVisionCenters.com