D'AMBROSIO Eye Care INC.

Patient Referral Form

Patient Name_____ Date of Referral_____
Date of Birth_____ Referred By_____
Patient Phone #_____ Practice Name_____

How soon does your patient need to be seen?

__Immediately/Same Day __24-48 hours __3-5 days __1-2 weeks __1-3 months __As convenient for patient

Please fax this form to 978-728-5480

Type of Care Requested

☐ Cataract:
Eye(s) Involved: __OD __OS __Nuclear __Cortical __Posterior Subcapsular __Congenital
Best Correctable Spectacle Visual Acuity: OD 20/____ OS 20/____
Have you discussed IOL options (monofocal, multifocal, monovision) with your patient? __Yes __No
Is your patient a candidate for a multifocal IOL or monovision? __Yes __No
Are you interested in comanaging your patient's post-operative care? __Yes __No
Please fax copy of most current examination to 978-728-5480 when appointment is made

☐ Retina:
__Diabetic Retinopathy __Break/Tear/Hole __Macular Degeneration __Vascular Occlusion __Nevus/Lesion
Eye(s) Involved: __OD __OS Quadrant/Location_____
Current/Previous Treatment_____

☐ Glaucoma:
Maximum IOP: OD_____ OS_____ C/D Ratio: OD_____ OS_____ Changes in C/D ratio or Rim? __Yes __No __Unknown
Any concerns for narrow or closed angles: __Yes __No
Current/Previous Treatment_____
If available, please fax copies of previous/current OCTs and Visual Fields to 978-728-5480 when appointment is made

☐ Cornea/Anterior Segment:
__Ulcer __Infection/Inflammation __Keratoconus __Scar/Opacity __Dystrophy/Degeneration __Pinguecula/Pterygia
__Other – Suspect Diagnosis:_____
Eye(s) Involved: __OD __OS Location_____

☐ Oculoplastics:
__Lid Lesion __Dermatochalasis __Lagophthalmos __Other:_____
Lid(s) Involved: __Right Upper __Right Lower __Left Upper __Left Lower

☐ Peds/Strabismus:
__Exotropia __Esotropia __Vertical Deviation Details_____
__Nystagmus __Other:_____
Eye Involved: __OD __OS

☐ Dry Eye:
Current/Previous Treatment_____

Additional information: _____
_____
_____
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