1805 EL CAMINO REAL, SUITE 100 • PALO ALTO, CA • 94306
2512 SAMARITAN COURT, SUITE K • SAN JOSE, CA • 95124
PHONE: (650) 324-9200 • FAX: (650) 326-5793

Referring Dr. Name: _____

Phone: _____ Fax: _____

Patient's Name: _____

Phone: _____ DOB: _____

Insurance: _____ □ HMO □ PPO

Date of Consult: _____

Reason for Referral:

□ IOP OD: _____ OS: _____

□ Glaucoma Evaluation

□ Abnormal Visual Field

□ Cataract Surgery Evaluation

□ Other _____

_____

_____

Service(s) requested

□ Glaucoma Consultation

□ Cataract Consultation

□ Disc Photos

□ OCT

□ HVF

□ Other:

*Please attach most recent chart notes, tests, insurance cards, and authorization

*If HMO insurance, please pull an authorization (Please contact our office for the required CPT codes)