SOMERSET
OPHTHALMOLOGY

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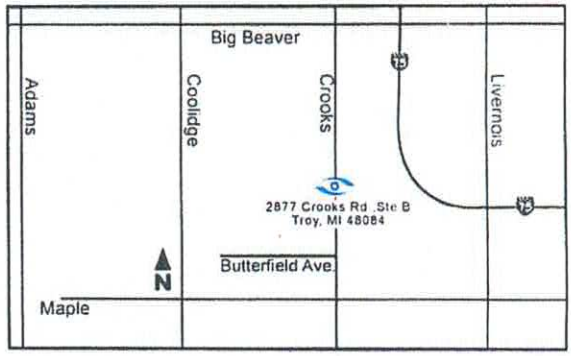

Consultation Referral Form (Please bring this form to your appointment)

Appointment Date:_____ Time: _____AM/PM

NAME:_____Date of Birth:_____

Address:_____

Phone:_____Insurance Type:_____

REFERRING DOCTOR

Name:_____Location:_____

Phone:_____ Fax:_____

Preferred Method of Communication: ☐ Letter ☐ Fax ☐ Phone

REASON FOR EVALUATION

- ☐ Diabetic Eye Exam
- ☐ Cataract Evaluation
- ☐ Glaucoma Evaluation
- ☐ HTN Evaluation
- ☐ Macular Degeneration Evaluation
- ☐ Plaquenil Eye Exam
- ☐ Visual Disturbance Evaluation
  - ☐ Flashes / Floater Evaluation
  - ☐ Visual Field Defect
- ☐ Diplopia Evaluation
- ☐ Ptosis Evaluation
- ☐ Papilledema Evaluation
- ☐ Eye Lid Lesion Evaluation
- ☐ Eye Pain Evaluation
  - ☐ Conjunctivitis
  - ☐ Irritation / Discomfort
  - ☐ Dry Eyes / Allergies
- ☐ LASIK / PRK Evaluation
- ☐ Cornea Evaluation
  - ☐ Corneal Infection
  - ☐ Corneal Scar
  - ☐ Keratoconus
  - ☐ Pellucid Marginal Degeneration
- ☐ Specialty Contact Lenses
  - ☐ RGP CL
  - ☐ Scleral CL
- ☐ Pediatric Vision Examination
  - ☐ Strabismus
  - ☐ Amblyopia Evaluation & Management
- ☐ Binocular Vision Disorders
- ☐ Low Vision
- ☐ OTHER:

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