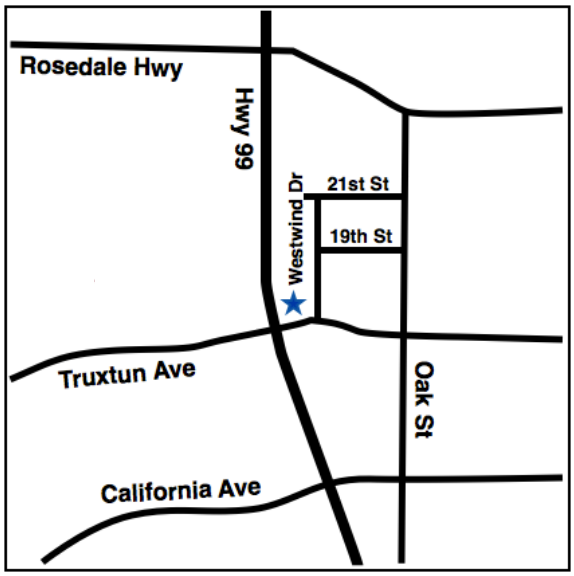
ADVANCED CENTER *for* EYECARE

Referral for Consultation:

Phone: 661-215-1006 • Fax: 661.324.1172

Pt Name: _____DOB: _____Today's Date: _____

Appointment Date/Time: _____



❑ 1721 Westwind Drive Suite B

Bakersfield, CA 93301

If the patient has an HMO plan, please obtain referral authorization.

Referring Doctor: _____

Reason for Consultation:

- ❑ Cataract Eval
- ❑ Glaucoma Eval
- ❑ Diabetic Exam
- ❑ Low Vision Eval
- ❑ Other:

VA: OD 20 / _____

OS 20 / _____

MRx: OD = 20 / _____

OS = 20 / _____

Service Requested:

- ❑ 2nd Opinion Only
- ❑ Consultation
- ❑ Co-management

Referring Doctor Signature:_____

PLEASE BRING THIS SHEET TO YOUR APPOINTMENT.