CALIFORNIA
Eye Surgeons

# OPHTHALMOLOGY SURGERY REFERRAL FORM

Patient Name: _____

Date of Birth: _____

Patient Phone: _____

Insurance: _____

INDICATION FOR CONSULT:

☐ Cataract Surgery

☐ Glaucoma Laser / Glaucoma Consult

☐ Dry Eyes / Lipiflow

☐ Pterygium Surgery

☐ Other/Comments: _____

_____

_____

_____

_____

_____

Doctor Requesting Consult: _____

Requesting Doctor's Tel #: _____ Fax #: _____

Report should be: ☐ Faxed ☐ Mailed

*Putting Patient Care First*

California Eye Surgeons • www.CalEyes.com

5330 Camden Avenue • **SAN JOSE, CA** 95124 • Tel: 408-940-3930 • Fax: 408-940-3945
7652 Monterey Street, Suite B • **GILROY, CA** 95020 • Tel: 408-842-2500 • Fax: 408-940-3945

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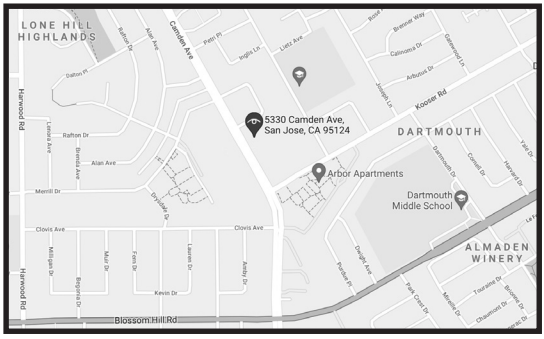
To the patient: Please bring this form with you to your appointment.
Please notify us within 48 hours if you are unable to keep your appointment.

**Your appointment with California Eye Surgeons has been set for:**

Date: _____ Time: _____

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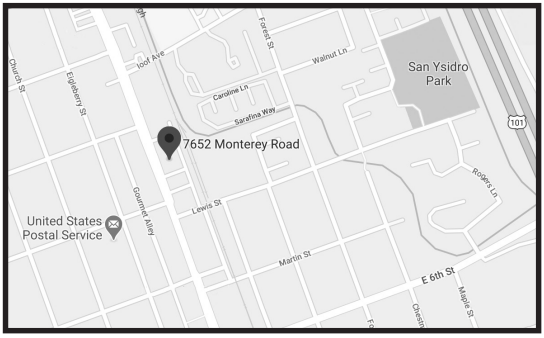


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