Specialty Eye Care

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Patient Referral

Doctor's Name:_____

Phone:_____ Fax:_____

Patient Name:_____ Patient Phone:_____

Reason for Referral – Chief Complaint, Past history, Visual Acuity, Intraocular Pressures, etc.

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Please Indicate:

☐ One time consult
☐ Follow patient along with me
☐ Co-manage
☐ Diagnose and treat this problem
☐ Transfer complete management
☐ I will follow for routine care only

Other:_____

If you would like us to do testing only, please circle what you would like done:

Visual Fields:	Humphrey - SWAP - Goldmann - FDT
Nerve/ Fiber Analysis:	HRTIII – Spectral domain OCT (RNFL)
Other:	Stereo disc photos – Immersion A-scan – IOL master -OCT macula scan
	High Resolution B-scan – Endothelial Cell Count – Pentacam

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11960 Lioness Way #190
Parker, CO 80134

Littleton Office (West Denver)
6179 S Balsam Way #130
Littleton, CO 80123

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