

## REFERRAL FORM

Dr. Christopher Hanson

PATIENT INFORMATION	
Name:	AHC#:
Date of Birth (yyyy/mm/dd):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	
Phone:	Cell:

REFERRING CLINIC INFORMATION	
Referring Physician:	Referring Clinic:
Phone:	Fax:
Practice ID #:	Date:
Urgency of Referral: <input type="checkbox"/> Within 48 Hours <input type="checkbox"/> Within a Week <input type="checkbox"/> Within a Month <input type="checkbox"/> Elective	
This referral for transfer of care <input type="checkbox"/> Yes <input type="checkbox"/> No	Co-Management of this patient is desired? <input type="checkbox"/> Yes <input type="checkbox"/> No

CONDITION(S)			
<input type="checkbox"/> Cataract	<input type="checkbox"/> Medical Glaucoma	<input type="checkbox"/> Sudden Loss of Vision	<input type="checkbox"/> Dry Eye
<input type="checkbox"/> YAG Capsulotomy	<input type="checkbox"/> Optic Nerve	<input type="checkbox"/> Thyroid Eye Disease	<input type="checkbox"/> Cornea
<input type="checkbox"/> IOL Opacity / Dysphotopsia	<input type="checkbox"/> Narrow Angles / LPI	<input type="checkbox"/> Pediatric Ophthalmology	<input type="checkbox"/> Other:
<input type="checkbox"/> Lipid Mass / Chalazion	<input type="checkbox"/> AMD (Wet / Dry)	<input type="checkbox"/> Pterygium	
<input type="checkbox"/> Strabismus	<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Uveitis	
<input type="checkbox"/> Amblyopia	<input type="checkbox"/> Plaquenil	<input type="checkbox"/> Ptosis	
VA: OD	OS	IOP: OD	OS
Comments:			