Cloudbreak EYE CARE

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GLAUCOMA | ADVANCED ANTERIOR SEGMENT RECONSTRUCTION | GENERAL & CATARACT

# REFERRAL FORM

## Dr. Patrick Gooi

| PATIENT INFORMATION | |
|---|---|
| Name: | AHC#: |
| Date of Birth (yyyy/mm/dd): | Gender: ❒ Male ❒ Female |
| Address: | |
| Phone: | Cell: |

| REFERRING CLINIC INFORMATION | |
|---|---|
| Referring Physician: | Referring Clinic: |
| Phone: | Fax: |
| Practice ID #: | Date: |
| Urgency of Referral: ❒ Within 48 Hours ❒ Within a Week ❒ Within a Month ❒ Elective | |
| This referral for transfer of care ❒ Yes ❒ No | Co-Management of this patient is desired? ❒ Yes ❒ No |

| CONDITION(S) | | | |
|---|---|---|---|
| ❒ Medical Glaucoma | ❒ Cataract | ❒ Sudden Loss of Vision | ❒ Diabetic Retinopathy |
| ❒ Surgical Glaucoma | ❒ YAG Capsulotomy | ❒ Pterygium | ❒ AMD (Wet / Dry) |
| ❒ SLT / MLT | ❒ Dislocated IOL / Lens | ❒ Dry Eye | ❒ Other: |
| ❒ Narrow Angles / LPI | ❒ IOL Opacity / Dysphotopsia | ❒ Optic Nerve | |
| ❒ Cyclophotocoagulation | ❒ Iris Defect | ❒ Uveitis | |

| VA: | OD | OS | IOP: | OD | OS |
|---|---|---|---|---|---|

Comments: