Western University of Health Sciences Eye Care Center

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For appointments:
Call **(909) 706-3946**
Fax (909) 469-5228

Referral for:

- ☐ Consultation
- ☐ Consult and Treatment
- ☐ Referral

Referral to:

- ☐ Low Vision
- ☐ Neuro-Rehabilitation
- ☐ Vision Therapy
- ☐ Pediatrics
- ☐ Specialty Contact Lens

Imaging / Structural Testing:

- ☐ Technical Component
- ☐ Technical Component with Interpretation:
  - ☐ Cirrus Visante OCT
  - ☐ Cirrus HD - OCT
  - ☐ Pachymetry
  - ☐ A/B Scan Ultrasonography
  - ☐ Digital Photography –
  - ☐ Ant or Post segment
  - ☐ Corneal Topography
  - ☐ Ocular Response Analyzer
  - ☐ OPD Scan II/3D Wave

Functional Testing:

- ☐ Preferential HyperAcuity Perimeter
- ☐ Standard Automated Perimetry (Humphrey)
- ☐ Kinetic Automated Perimetry (Octopus 900)
- ☐ Frequency Doubling Perimetry (FDT)
- ☐ Diopsys VEP
- ☐ Readalyzer / Visagraph III
- ☐ Strabismus Evaluation
- ☐ Amblyopia Evaluation
- ☐ Visual Efficiency
- ☐ Visually Related Learning Problem

YAG Laser Procedure:

- ☐ Peripheral Irridotomy
- ☐ Posterior Capsule Opacification

Other Pertinent Information:

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Date of Referral

____
Patient Name

____
Patient Address

____
City State Zip

____
Patient Phone# Patient Email

Diagnosis:____________________________

Date of last exam:____________________________

Most Recent Refraction:

OD 20/

OS 20/

____
Referred by

____
Address of Referring Provider

____
City State Zip

____
Phone# Fax#

____
Referring Provider's E-mail Address

Provider's Preferred Correspondence:

- ☐ Phone Call
- ☐ Mail
- ☐ Fax
- ☐ Email