ADV Vision Referral Form

Date:

Patient Name:

Patient DOB:

Referring Physician:

Phone:

Fax:

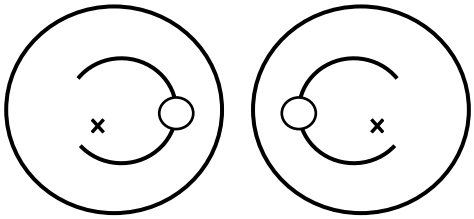
Patient Phone:

Patient Email:

Insurance:

If the patient has an HMO and this is their first time at our office, an authorization from the patient's PCP will be needed before they can be seen. Please send a copy of patient's insurance cards and last appointment notes.

BRIEFLY STATE THE REASON FOR THE REFERRAL



DIAGNOSIS	REQUESTED APPT. TIMEFRAME	OFFICE REQUESTED	Doctor
○ Cataract ○ Strabismus ○ YAG ○ Blurry Vision ○ Macular Degeneration ○ Glaucoma Screening ○ General Ophthalmology ○ Blepharoplasty ○ Pterygium ○ Red Eye ○ Eye Exam ○ Other: _____ **Cataract Discussion** ○ Laser Assisted ○ Premium Lens Package ○ Economy Lens Package ○ Basic Lens Option	○ Immediately (Please call us directly) ○ Within one week ○ Within one month ○ When patient prefers ○ Other: _____ **Preferred Communication** ○ Call ○ Text ○ Email ○ All the above	○ 104 Gateway Center Suite B Paso Robles, CA 93446 ○ 835 Aerovista Lane #110 San Luis Obispo, CA 93401 ○ 821 E. Chapel Street #102 Santa Maria, CA 93454	○ Adam D Abroms, M.D.

What is one unique thing about this patient (IE hobbies, activities, etc)?

Are there any special event(s) in this patient's life coming up?

Submit Referral Via: Phone: (805) 987-5300 Fax: (805) 621-7737 Email: referrals@doughertylaservision.com