Lifetime Optometric
1111 East Herndon Avenue, #101
Fresno, CA 93720
Office (559) 432-2200/Fax (559) 432-2203
www.lifetimeoptometric.com

Fax Referral Form

TO: Lifetime Optometric FAX TO: (559) 432-2203

DATE: _____TIME: _____No. Pages (including cover sheet) _____

Lifetime Optometric will contact your patient for an appointment.

FROM:

Referring Doctor:_____Contact:_____

Office Address_____

Phone:_____Fax:_____Email (optional):_____

Reason for Consultation:_____

- ❑ Dry Eye Consult
- ❑ Comprehensive Eye Examination
- ❑ Contact Lens Examination –If a previous contact lens wearer, please advise patient to bring their contact lens boxes/blister packs and to wear their contacts.
- ❑ Manifest Refraction only (co-management with ophthalmologist)

Comments: _____

PATIENT INFORMATION: (please attach any relevant notes)

Name: _____DOB: _____ Sex: _____

Address:_____

Home Phone: _____Work Phone: _____ Cell:_____

Vision/Medical Insurance: _____

SCHEDULED FOR EXAMINATION with Lifetime Optometric: Date: _____ Time: _____

Comments: _____

THANK YOU FOR YOUR REFERRAL