

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**

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