KETCHUM HEALTH
University Eye Center

General Referral / Consultation Form

5460 E. La Palma Ave. | Anaheim, CA 92807 | P 714.463.7500 | F 714.992.7811

Patient Name: _____ **DOB:** _____

Address: _____

Phone Number: _____

To assist in caring for your patients, please provide current clinical notes or patient record. This will allow us to avoid repeating services.

Diagnosis / Reason for Referral: _____

_____

_____

Pertinent Clinical Findings: _____

_____

_____

_____

Did you perform a comprehensive eye examination?

☐ Yes ☐ No Date of last eye exam: _____ Date of last dilation: _____

Please choose the appropriate evaluation, program, and / or testing required from the list below:

☐ Binocular Vision Evaluation: Vision Therapy / Strabismus / Amblyopia	☐ Pachymetry	☐ Dry Eye
☐ Corneal Topography	☐ Specialty Contact Lens Fitting	☐ Electrodiagnostics
☐ Low Vision Evaluation	☐ Threshold Visual Fields	☐ Myopia Control
☐ OCT (Anterior / Posterior Segment)	☐ Other (please list): _____	☐ Prosthetic Fit
		☐ Sports Vision Evaluation

May we contact the patient for an appointment? ☐ Yes ☐ No

Would you like copies of the testing and/or a report of our findings? ☐ Yes ☐ No

Referring Physician: _____

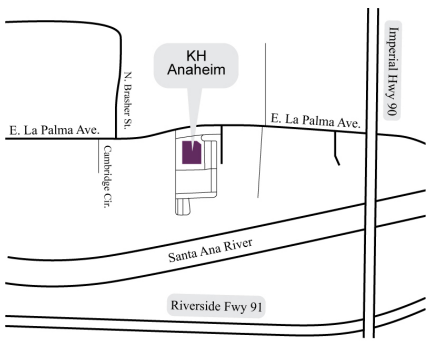
Address: _____

Email: _____

Phone Number: _____ **Fax:** _____

Please fax this form with any pertinent patient records to 714.992.7811

Thank you for your referral.
We look forward to working with you!



University Eye Center at Ketchum Health Anaheim
P 714.463.7500 | F 714.992.7811 | ketchumhealth.org