SPECIALTY SERVICES

CONSULTATION / REFERRAL FORM

University Eye Center at Fullerton | 2575 Yorba Linda Boulevard, Fullerton, CA 92831

UNIVERSITY EYE CENTER *at Fullerton*

Please fax this form, ALONG WITH ANY PATIENT RECORDS, to the service below.

Please check types of specialty services needed:	Service Phone #	Service Fax #
☐ **Dry Eye:** Dry Eye Institute	714.449.7420	714.992.7833
☐ **Contact Lenses:** Stein Family Cornea & Contact Lens Center	714.449.7420	714.992.7833
☐ **Low Vision:** Mary Ann Keverline Walls Low Vision Rehabilitation Center	714.992.7890	714.992.7863
☐ **Ocular Disease:** Ocular Disease / Ophthalmology / Electrodiagnostic Service	714.449.7415	714.992.7848
☐ **Ocular Prosthetics:** Stein Family Cornea & Contact Lens Center	714.449.7420	714.992.7833
☐ **Pediatrics:** Pediatric Vision Care	714.992.7870	714.992.7856
☐ **Research:** Center for Vision Research	714.449.7490	714.992.7864
☐ **Vision Therapy:** Studt Center for Vision Therapy	714.449.7430	714.992.7846

Sent by:

Doctor's Name: _____ Doctor's NPI # (***required***): _____

Office Address: _____

City: _____ State: _____ Zip: _____

Office Phone #: _____ Fax #: _____

Email: _____ ☐ *I prefer electronic correspondence*

Introducing:

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Contact Phone #: _____

I am sending the above patient to the Eye Care Center for the following reasons:

☐ Consultation / 2nd Opinion Only (pt to be returned to original doctor) ☐ Special Testing Only

☐ Transfer of Care (referral) ☐ Treatment/Therapy (further information may be needed upon request)

Other/Comments/Special Requests/Tests Requested: _____

_____

_____

Would you like us to contact the patient for an appointment? ☐ Yes ☐ No

Please fax this form, ALONG WITH ANY PATIENT RECORDS, to the service above.

Signed _____ Date _____