KETCHUM HEALTH
University Eye Center

General Referral / Consultation Form

☐ **University Eye Center at Ketchum Health Anaheim**
5460 E. La Palma Ave. | Anaheim, CA 92807
P 714.463.7500 | F 714.992.7811 | ketchumhealth.org

☐ **University Eye Center at Ketchum Health Los Angeles**
3916 S. Broadway | Los Angeles, CA 90037
P 323.234.9137 | F 323.235.6203 | ketchumhealth.org

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

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

Patient referred for: ☐ Consultation ☐ Special testing ☐ Transfer of care ☐ Evaluation and Treatment

Referring Physician: _____

Address: _____

Email: _____

Phone Number: _____ **Fax:** _____

Please email this form with any pertinent patient records to refer@ketchum.edu

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