KETCHUM HEALTH
University Eye Center

General Referral / Consultation Form

3916 S. Broadway | Los Angeles, CA 90037 | P 323.234.9137 | F 323.235.6203

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: _____

Special Testing Requested:

☐ Threshold Visual Fields

☐ Pachymetry

☐ Specialty Contact Lens Fitting

☐ Binocular Vision Evaluation:
Vision Therapy / Strabismus / Amblyopia

☐ OCT (Anterior/Posterior Segment)

☐ Corneal Topography

☐ Low Vision Evaluation

☐ Other: _____

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: _____

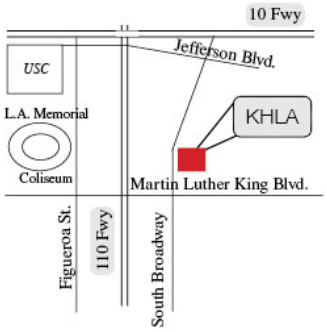
Address: _____

Email: _____

Phone Number: _____ **Fax:** _____

Please fax or email this form with any pertinent patient records to 323.235.6203 or Medrecordsla@ketchum.edu

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



University Eye Center at Ketchum Health Los Angeles
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