EYE CARE OF DELAWARE LLC

To: ☐ Dr. Jeffrey R. Boyd ☐ Dr. Paul C. Mitchell
☐ Dr. Jurij R. Bilyk ☐ Dr. Carl H. Park

I have examined this patient and am referring him/her to you for a consultation.

_____ _____
Date of Appointment Patient's Name

_____ _____
Referred by Patient's Address

_____ _____
Office Location Patient's City, State, Zip

_____ _____
Office Phone Number Patient's Phone Number and Date of Birth

Reason(s) for Referral (check all that apply): please use separate pre-op form for cataract referrals

☐ Glaucoma Evaluation ☐ Retinal Evaluation ☐ Oculoplastic Evaluation

☐ Other _____

Diagnosis:_____

Pertinent Symptoms, History:_____

_____

REF OD _____ VA_____

OS _____ VA_____

Tonometry (Check one): ☐ Non-Contact ☐ Applanation

OD _____ mmHg OS _____ mmHg

Examination Findings: _____

_____

_____

Procedure Requested: _____

Signed:_____ Date: _____

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