KELLIS EYE & LASER CENTER

PATIENT REFERRAL FORM

SEE REVERSE SIDE FOR OFFICE LOCATIONS

Patient Name _____ **Date of Birth** _____

Patient Phone Number_____ **Today's Date** _____

Referred To:

Augustine J. Kellis, M.D., F.A.C.S., F.A.A.O. _____ Julieta Ryder, M.D. _____

Gene Aidan Johnson, M.D., F.A.A.O. _____ First Available Surgeon _____

Referred By:

Dr. Name and Practice Name

_____

Office Mailing Address

_____

Office Phone and Fax

_____

Reason for Referral:

- Cataract Consultation **(CHARDON OFFICE ONLY)**

  (OD OS OU)

  Lenses Discussed

  ___ Standard Lens

  ____ Premium Lens (____ Multifocal ____ Toric)

  Cataract Co-Management

  _____Yes _____ No

  (If yes, please also fax over co-manage consent form)

  Insurance _____

- Oculoplastic Evaluation

  Condition to Evaluate_____

  Other Information_____

- HALO™/BBL™/SkinTyte™ Consultation

  _____

Referring Physician Signature _____

Printed Signature _____

Scheduled Appt _____/_____/_____ @ _____A.M. P.M. LOCATION _____