

Omni Eye Specialists

55 Madison St. Ste 355, Denver, CO 80206
303-377-2020/303-377-2022 (Fax)

Referral Form

Referring Doctor _____

Patient Name _____

Date _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

DOB _____

Phone _____

Phone _____

Fax _____

*Patient scheduled at Omni on _____

E-mail _____

*Omni to schedule patient: Y N

*Other _____

Check if change in Dr's:

Address Phone E-mail

Your patient will be scheduled appropriately.

Please call us if this is an urgent matter.

Reason for Referral: (please circle)

Retina Cornea Oculoplastics Cataract Anterior Segment Lacrimal Plugs
Glaucoma (Do you wish to co-manage? Y N) Visual Field/GDX or OCT: testing only. (No consult with doctor.)
Rule out pathology prior to refractive surgery: **Specify GDX or OCT.**
Retina consult Visual Field/GDx or OCT. (No consult with doctor.)

Pertinent symptoms/History:

BCVA OD _____ VA _____ **Tonometry** OD _____ mmHg App.
OS _____ VA _____ Time _____ OS _____ mmHg NCT

Procedures Specifically Requested: Anterior Segment Photos Posterior Segment Photos
Visual Field (24-2/30-2) GDx OCT OrbScan Pachymetry Potential Acuity Meter
PHP Specular Microscope As Necessary Other _____

****If you have a doctor or surgeon preference, please CIRCLE. We will do our best to accommodate your request****

First Available

Ant. Segment:	Pardos	Prouty	Jordan	Wang	Belen	Amiel	No Preference	
Cataract:	Pardos	Prouty	Jordan	Wang	Belen	Amiel	No Preference	
Cornea:	Prouty	Jordan	Wang	Amiel			No Preference	
Glaucoma:	Prouty	Jordan	Belen	Amiel			No Preference	
Oculoplastics:	McCracken						No Preference	
Retina:	Reeves	Teeter					No Preference	
Surgeon:	Pardos	Wang	Belen	Reeves	McCracken	Amiel	Teeter	First Available

Referring Doctor Signature: _____

RETURN ADDRESS REQUESTED

Omni Eye Specialists
55 Madison, Suite 355
Denver, Colorado 80206