2180 N. Causeway Blvd. Ste. 10
Mandeville, Louisiana 70471

OFFICE: 985-202-5626
FAX: 985-256-4840

PLEASE COMPLETE ALL AREAS IN RED.

Patient ______________________________ Date ____________________

Address ______________________________ Telephone ____________________

I hereby grant permission for the practitioner named below or any other practitioner involved in my care to exchange information concerning my case, history, results, or examination, diagnosis, treatments, etc.

______________________________ ____________________

Signed ☐Parent ☐Guardian Date

Reason For referral:

- ☐ Cataract Evaluation
- ☐ Specialty Rigid Contact Lens
- ☐ Age Related Macular Degeneration
- ☐ Pediatric Eye Exam
- ☐ Eye Injury Assessment
- ☐ High Risk Medicine Use Evaluation
- ☐ Glaucoma Evaluation
- ☐ Retinal Evaluation
- ☐ Diabetic Eye Exam
- ☐ Eye Infection Assessment
- ☐ Laser Treatment (SLT/LPI/YAG CAP)
- ☐ Other
- ☐ Neurological Eye Disorder Evaluation
- ☐ Headache Triage
- ☐ Retinal Detachment/Tear/Hole Evaluation
- ☐ Ocular Surface Disease Evaluation
- ☐ Routine Vision Assessment

Remarks: ____

Results of Examination:

Refraction OD ____________________
OS ____________________

Tonometry OD ____________________mmHg
OS ____________________mmHg

BCVA OD 20/ ____________________
OS 20/ ____________________

Referred By: ______________________________

Location: ______________________________

Phone: ______________________________

IMPORTANT: Please ask all patients to bring their current medication list (ocular and systemic) and all insurance cards with them to the clinic.