



PATIENT REFERRAL for CATARACT SURGERY

Date: _____

Referring OD: _____

Contact Person/Phone#: _____

PATIENT INFORMATION: (Please Print)

Patient Name: _____ Sex: M F

Street Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ Insurance: _____

Email Address: _____

Please circle all that apply:

Current Correction: Glasses Only Hard/RGP Daily Wear SCL Toric SCL

Patient Rx: OD _____ - _____ x _____ OS _____ - _____ x _____

Previous Eye Surgery: Yes / No If yes, type of surgery: _____

Significant ocular conditions: Dry eyes / Glaucoma / ARMD / ERM / Other: _____

Desired Type of IOL: Standard monofocal / Toric monofocal / Multifocal IOL / Unsure

Desired Correction: Distance OU / Near OU / Monovision / Multifocal IOL / Unsure

If Monovision, please specify: **OD** (Dist / Near) and **OS** (Dist / Near)

Would you like to Co-Manage? Yes No

Comments:

PLEASE FAX TO: (808) 599-4818

1100 WARD AVENUE SUITE 1000 HONOLULU, HAWAII 96814 ❖ PHONE: 808.792.3937 FAX: 808.599.4818

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