TAILORED EYES

Please fax this completed form to:
Dr. Steven Kane
Fax: 941-499-1571

PATIENT REFERRAL FORM

Referring Provider: _____
HISP#: _____ **NPI:** _____
Address: _____
Phone: _____ **Fax:** _____

Patient Name: _____
Date of Birth: _____ Preferred Phone: _____

Affected Eye(s)

- ❑ Left eye
- ❑ Right eye
- ❑ Both

BCVA OD: _____ OS: _____

IOP OD: _____ OS: _____

Reason for referral (please check all that apply):

- ❑ Blurry vision
- ❑ Cataract
- ❑ Cornea dystrophy
- ❑ Corneal edema
- ❑ Cornea erosion
- ❑ Corneal scar
- ❑ Cornea transplant
- ❑ Corneal ulcer (contact lenses? YES/NO)
- ❑ Diabetic eye exam
- ❑ Dry eye
- ❑ Eye pain
- ❑ Foreign body
- ❑ LASIK
- ❑ Glaucoma evaluation
- ❑ Macular degeneration
- ❑ Ocular surface lesion
- ❑ Pterygium
- ❑ Shingles evaluation
- ❑ Second opinion: _____ _____
- ❑ Other: _____ _____

Past Ocular History/Surgery:

- ❑ Cataract Surgery
- ❑ Cornea transplant
- ❑ Glaucoma
- ❑ Herpes/shingles
- ❑ Retinal detachment (history of vitrectomy? YES/NO)

Thank you for the opportunity to help care for your patients!

Tailored Eyes by Steven Kane, MD
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TailoredEyes.com

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