

**SPECIALTY SERVICES
CONSULTATION / REFERRAL FORM**

2575 Yorba Linda Blvd. • Fullerton, CA 92831



Please fax this form, ALONG WITH ANY PATIENT RECORDS, to the service below.

Please check types of specialty services needed:	Service Phone #	Service Fax #
<input type="checkbox"/> Dry Eye: Dry Eye Institute	714.449.7420	714.992.7833
<input type="checkbox"/> Contact Lenses: Stein Family Cornea & Contact Lens Center	714.449.7420	714.992.7833
<input type="checkbox"/> Low Vision: Mary Ann Keverline Walls Low Vision Rehabilitation Center	714.992.7890	714.992.7863
<input type="checkbox"/> Ocular Disease: Ocular Disease / Ophthalmology / Electrodiagnostic Service	714.449.7415	714.992.7848
<input type="checkbox"/> Ocular Prosthetics: Stein Family Cornea & Contact Lens Center	714.449.7420	714.992.7833
<input type="checkbox"/> Pediatrics: Pediatric Vision Care	714.992.7870	714.992.7856
<input type="checkbox"/> Research: Center for Vision Research	714.449.7490	714.992.7864
<input type="checkbox"/> Vision Therapy: Studt Center for Vision Therapy	714.449.7430	714.992.7846

Sent by:

Doctor's Name: _____ **Doctor's NPI #** _____
(required)

Office Address: _____

City/State/Zip: _____

Office Phone #: _____ Fax #: _____

Email: _____ *I prefer electronic correspondence*

Introducing:

Name: _____ DOB: _____

Address: _____

City/State/Zip: _____

Phone: _____ Contact Phone #: _____

I am sending the above patient to the Eye Care Center for the following reasons:

- Consultation / 2nd Opinion Only (pt to be returned to original doctor) Special Testing Only
 Transfer of Care (referral) Treatment/Therapy (**further information may be needed upon request**)

Other/Comments/Special Requests/Tests Requested: _____

Would you like us to contact the patient for an appointment? Yes No

Please fax this form, ALONG WITH ANY PATIENT RECORDS, to the service above.

Signed _____ Date _____