

Patient Referral Form



**EYE ASSOCIATES
OF ORANGE COUNTY**

An NVISION® Eye Center

- Omar Krad, MD
- Luis Chanes, MD
- Rose Cunningham-Ahumada, DO

BOARD-CERTIFIED CATARACT AND REFRACTIVE SURGEON

DEDICATED CONSULT FAX LINE 714-557-7710 

Referring Doctor

Date _____

Referred by _____

Office Phone _____ Office Fax _____

Patient Information

Patient Name _____

Patient Tel _____

Patient Email (if preferred) _____


Reason for Consult

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Flashes / Floaters |
| <input type="checkbox"/> LASIK / PRK | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Retinal Tear / Detachment |
| <input type="checkbox"/> Diabetes / HTN | <input type="checkbox"/> Pterygium | <input type="checkbox"/> Choroidal Nevus vs Melanoma |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Droopy Lids | <input type="checkbox"/> Other _____ |


Follow-Up Date

- Emergent Within 1 week Next Available

 27871 Medical Center Road, Suite 120
Mission Viejo, CA 92691

 Tel (949) 364-6688

 2621 S. Bristol Street, Suite 205
Santa Ana, CA 92704

 Tel (714) 557-5777

Dear patient, please bring this form with you to your appointment. Thank you!