OPHTHALMIC
SURGEONS & PHYSICIANS

Tempe
3200 S. Country Club Way
Tempe, AZ 85282

Sun Lakes
25229 S. Sun Lakes Blvd, STE 202
Sun Lakes, AZ 85248

Ahwatukee
5110 E. Warner Rd, STE 150
Phoenix, AZ 85044

P: 480-839-0206 **F:480-839-0208**

PATIENT REFERRAL FORM

Date: _____
Referring Doctor: _____
Office Phone Number_____ Location_____
Patient's Name: _____ Date of Birth_____
Cell Phone #_____ Home Number#_____
Address_____
Patient's Medical Insurance_____

Referral Recommendation: Comanage? Please Circle exam request.

Cataract Evaluation	☐ Yes	☐ No	Oculoplastic Evaluation	☐ Yes	☐ No
YAG Evaluation	☐ Yes	☐ No	Glaucoma Evaluation	☐ Yes	☐ No
LASIK/PRK Evaluation	☐ Yes	☐ No	Cornea Evaluation	☐ Yes	☐ No

Concern_____

Provider Referring to:

- ☐ Camille Hylton, MD
- ☐ Emmanuel Kai-Lewis, MD
- ☐ Lisa Mansueto, MD
- ☐ Jacquelyn Laplant, MD
- ☐ Bertram Matsumoto, MD
- ☐ Danielle Remington, OD
- ☐ Bryan Grossman, OD

Comanagement Agreement Cataract / Yag Laser / LASIK

I_____voluntarily, knowingly, and willingly desire to have Dr._____ my Optometrist, perform follow-up care after my surgery. I understand the risks, benefits and logistics of this arrangement and I desire to proceed.

Patient signature_____
Optometrist Signature_____
Surgeon's signature _____