NEW YORK MEDICAL & SURGICAL
EYE CARE

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New York, NY 10016
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PATIENT REFERRAL FORM

Patient Name: _____

Patient Email: _____

Patient Phone: _____

Referring Doctor: _____

Phone: _____ Fax: _____

Reason for Consultation (mark all that apply)

- ☐ Cataract Evaluation
- ☐ Glaucoma Evaluation
- ☐ Comprehensive Eye Exam
- ☐ Diabetic Eye Exam
- ☐ Hypertension
- ☐ Macular Degeneration Evaluation
- ☐ Pediatric Evaluation
- ☐ Dry Eye
- ☐ Red Eye
- ☐ Blurry Vision
- ☐ Flashes/Floaters
- ☐ Contacts/Glasses
- ☐ Other _____