SPECIALTY SERVICES

CONSULTATION / REFERRAL FORM

University Eye Center at Los Angeles | 3916 S. Broadway, Los Angeles, CA 90037

UNIVERSITY EYE CENTER
at Los Angeles

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

Please check types of specialty services needed:	Service Phone #	Service Fax #
☐ **Dry Eye**	323.234.9137	323.235.6203
☐ **Contact Lenses**	323.234.9137	323.235.6203
☐ **Low Vision**	323.234.9137	323.235.6203
☐ **Ocular Disease:** Ocular Disease / Ophthalmology / Electrodiagnostic Service	323.234.9137	323.235.6203
☐ **Ocular Prosthetics**	323.234.9137	323.235.6203
☐ **Pediatrics**	323.234.9137	323.235.6203
☐ **Research**	323.234.9137	323.235.6203
☐ **Vision Therapy**	323.234.9137	323.235.6203

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 _____