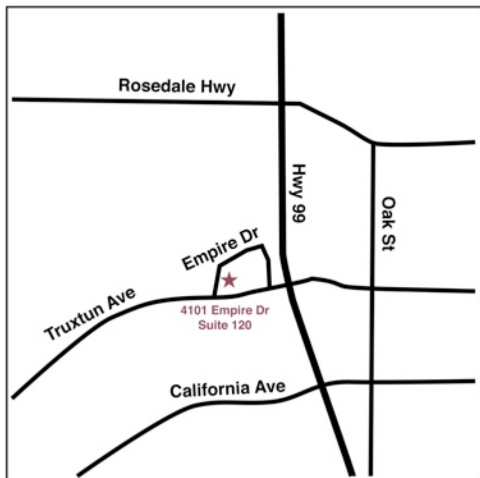
EMPIRE EYE AND LASER CENTER

www.empireeyeandlaser.com

Referral for Consultation: 661-325-3937

(1) FAX to 661-283-3937 and (2) Ask patient to bring this sheet EELC.

Patient Name: ______________________________ DOB: ______________ Today's Date: ______________



Appointment Date/Time:

____

Physician:
- ❑ Joseph Chang, M.D.
- ❑ Daniel Chang, M.D.

PLEASE BRING THIS SHEET TO YOUR APPOINTMENT

❑ Main Office
4101 Empire Drive, Suite 120
Bakersfield, CA 93309
661-325-3937

❑ Southwest Office
500 Old River Road, Suite 185
Bakersfield, CA 93311
661-664-9121

Reason for Consultation: ____ yo M / F
- ❑ Cataract Eval ❑ Glaucoma Eval
- ❑ Refractive Consult ❑ Other

VA: OD 20 / ____

OS 20 / ____

MRx: OD = 20 / ____

OS = 20 / ____

Referring Physician: **Dr.** ______________________

Contact Information/Additional Comments:

Service Requested:
- ❑ Consultation and Management
- ❑ 2nd Opinion Only

Response Requested:
- ❑ Send letter
- ❑ Fax note / call when seen: ____________

Referring Doctor Signature: ___________________________

PLEASE BRING THIS SHEET TO YOUR APPOINTMENT.

OD Referral for Consult, rev 8/26/09