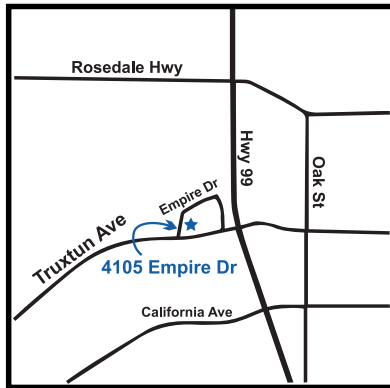


Referral for Consultation: 661-325-3937

Pt Name: _____ DOB: _____ Phone #: _____

Physician: Daniel Chang, M.D. Andrew Kao, M.D. Vin Dang, O.D.
 Laura Huggins, O.D. Ranjeet Bajwa, O.D. Jacqueline Albert, O.D.

Appointment Date/Time: _____ **Insurance:** _____



4105 Empire Drive
 Bakersfield, CA 93309
Fax: 661-283-3937

Referring Doctor: _____ **Today's Date:** _____

Reason for Consultation:

- Cataract Eval Refractive Consult
- Plastics Consult Glaucoma Eval
- Dry Eye Eval Annual Medical Exam
- Diabetic Eval Plaquenil Eval
- Other: _____

VA: OD 20 / _____

OS 20 / _____

MRx: OD = 20 / _____

OS = 20 / _____

Service Requested:

- Co-management
- Consultation and Management
- 2nd Opinion Only

Referring Doctor Signature: _____

PLEASE BRING THIS SHEET TO YOUR APPOINTMENT.