BEST PRACTICE
EYECARE

Dr. Michael J Karpa

Comprehensive Ophthalmologist

Laser, Cataract, Glaucoma and Oculoplastic Surgery
Macular Degeneration, Diabetic Retina and Botox
Treatment Provider No. 5683412A

REFERRAL TO OPHTHALMOLOGIST

Referring Practitioner _____ Date: _____

_____

_____ Prov. No: _____

Could you please see and assess:

PATIENT: Name: _____ D.O.B: _____

Address: _____

_____ Phone No. _____

_____

PROBLEM:

EXAMINATION:

Right Eye

VA R _____ u/a

R _____ with glasses

Subjective Refraction

R _____

IOP

R _____ mm Hg

Left Eye

VA L _____ u/a

L _____ with glasses

Subjective Refraction

L _____

IOP

L _____ mm Hg

ANT SEG:

POST SEG:

Regards _____ Referral valid for: 3 Months ☐ 12 Months ☐ other ☐

Signature