

EAST BAY EYE CENTER MEDICAL CORPORATION

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CORNEA, ANTERIOR SEGMENT, AND EXTERNAL DISEASE REFERRAL FORM

REFERRING PROVIDER: _____ DATE: _____

YOUR PHONE: _____ YOUR FAX: _____

Patient Name: _____ **PHONE (H)** _____

INSURANCE INFO: _____ **WORK/CELL** _____

Select the condition or procedure(s) for which this patient is being referred:

Diagnoses:

- | | |
|--|---|
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Blepharitis | <input type="checkbox"/> Conjunctivitis (acute, chronic, Cicatrizing) |
| <input type="checkbox"/> Ectasias (Keratoconus) | <input type="checkbox"/> Dystrophies (i.e. Fuchs') |
| <input type="checkbox"/> Band Keratopathy | <input type="checkbox"/> Ulcers (infectious & Inflammatory) |
| <input type="checkbox"/> Benign and Malignant Tumors | <input type="checkbox"/> Traumatic Scars |
| <input type="checkbox"/> Chemical Burns | |

Procedures:

- Cataract surgery
- Presbyopia-correcting intraocular lens implants
- Astigmatism-correcting toric intraocular lens implants
- Intraocular lens exchange
- Intraocular lens repositioning
- Astigmatism-correcting limbal relaxing incisions
- Corneal transplantation
- Combined cataract surgery and corneal transplantation
- Partial corneal transplantation (lamellar)
- Endothelial transplantation (DSEK)
- Limbal stem cell transplantation
- Phototherapeutic keratectomy
- Superficial keratectomy
- Stromal puncture
- Conjunctival autografting
- Amniotic membrane placement
- Pterygium excision
- Punctal occlusion/cauterization
- Calcium chelation
- BlephEx
- Other: _____

Comments: _____
