EAST BAY EYE CENTER MEDICAL CORPORATION
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OCULOPLASTIC REFERRAL FORM

REFERRING PROVIDER:_____DATE:_____

YOUR PHONE:_____ YOUR FAX:_____

PATIENT NAME:_____**PHONE (H)**_____

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

Please select the condition(s) for which this patient is being referred:

Oculoplastic Disorders:

- ☐ Blepharospasm
- ☐ Ptosis/Droopy Eyelids
- ☐ Ectropion
- ☐ Entropion
- ☐ Eyelid Lesions
  - ☐ Hordeolum/Chalazion
  - ☐ Papilloma/Cyst
  - ☐ Suspected Malignancy (for Mohs reconstructive surgery)
- ☐ Pterygium/Pinguecula
- ☐ Rosacea/Blepharitis
- ☐ Trichiasis

Lacrimal/Tearing Disorders:

- ☐ Epiphora
- ☐ Dacryocystitis/Infection
- ☐ Dry Eye Syndrome

Orbital Disorders:

- ☐ Enucleation or Anophthalmic socket
- ☐ Orbital Mass/Tumor
- ☐ Thyroid Eye Disease
- ☐ Traumatic Deformity/Fracture

☐ Cosmetic Consultation: _____

☐ Other: _____

Comments: _____