



BFVC Location

Sherman Oaks Burbank Arcadia Beverly Hills Valencia

Medical Consultation Referral Form

Last Name: _____ First Name: _____ Todays Date: _____

Gender: _____ Date of Birth: ____/____/____ Phone (____) _____ Mobile Home

Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Medical Insurance: _____
 Medicare PPO HMO (Facey/Axminster)

Procedure Discussed: OU / OD / OS

Cataract Glaucoma Eyelid Surgery Pterygium Chalazion Strabismus Corneal Diseases

Diabetes Aesthetics (Botox/Restylane/Juvederm/Latisse) Pediatric Other: _____

Comments: _____

Referring Doctor: _____ Office Location _____ (city only)
OD Phone: (____) _____ OD Fax: (____) _____
OD: Email: _____

Examination (or attach exam notes)

Ocular History: _____

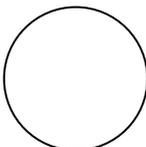
Medical History: _____

OD

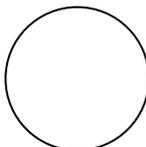
OS

Uncorrected Visual Acuity _____
20/____ Current Spectacles _____ 20/____
20/____ Add:____ Manifest Refraction _____ 20/____ Add:____
20/____ 1% Mydriacyl Refraction _____ 20/____
(or 1% Tropicamide)
Keratometry _____
Tonometry _____
(if available)
IOP _____

Dominant Eye: _____



____ Lids / Lashes / Lacrimal _____
____ Conjunctiva _____
____ Cornea _____
____ Anterior Chamber _____
____ Iris _____
____ Lens _____



C/D _____ Macula _____ Dilated Fundus Exam C/D _____ Macula _____
____ Periphery _____

Doctor's Signature: _____

Exam Date: _____

FAX TO 818.845.7068 or EMAIL TO info@bergfeinfield.com

FOR OFFICE USE ONLY: LASIK Consult Scheduled ____/____/____ @ Sherman Oaks / Burbank / Arcadia / Beverly Hills
Initial Call ____/____/____ Faxed to OD ____/____/____ (initials)
 Left message Spoke to patient, will check schedule and call back Not interested at this time, follow-up in ____ weeks / months