BENNETT WALTON

VISION

# Patient Referral Form

**Referring Doctor:** _____ **Office:** _____

**Office Contact Number:** _____ **Office Person of Contact:** _____

**Patient Name:** _____ **DOB:** _____

**Patient Phone:** _____ **Patient Email:**_____

**Patient Primary Insurance Info:** _____

**Patient Secondary Insurance Info:** _____

**Reason for Referral:**

- ☐ **Cataract** — **Eye:** ☐ **OD** ☐ **OS** ☐ **OU**
- ☐ **Custom Lens Exchange**
- ☐ **YAG Cap**
- ☐ **LASIK**
- ☐ **PRK**
- ☐ **Evo ICL**
- **Other:**_____

Co-Managed Care:

☐ **YES:** I am comfortable providing care for patient as soon as
☐ 1 day post op ☐ After 1 day post op ☐ After 1 month Other: _____

☐ **NO:** I would prefer Bennett Walton Vision to care for patient during post op period.

**Notes:**

**BennettWaltonVision.com**

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