Co-Management Referral Form

Please fax or e-mail to:

GORDON SCHANZLIN
NEW VISION INSTITUTE

Phone (858) 455-6800 Fax (858) 455-0244 e-mail rmartin@gwsvision.com

Referring Doctor_____Phone_____Date_____

Referring to: M. Gordon, M.D. D. Schanzlin, M.D.

A. Gordon, M.D. J. Echegoyen, M.D. ☐ No preference

Patient Name: _____DOB_____

Address:_____

Phone: Home_____Cell_____

E-mail:_____Occupation:_____

Reason for considering surgery/ expectations/ comments:_____

_____

Pre-Procedure Information

	Right	***Left***
Refractive Error		
Keratometry		
Iop		
Cornea		
A/C		
Lens		
Fundus		
Comments		

Contact Lens Use: ***PMMA*** ***GPC*** ***SOFT*** ***TORIC*** ***EWCL*** ***Last used on:*** _____

Monovision: No____Yes____ ***Eye for Near***: OD OS ***Power***: _____

Ocular History:

_____

Medical History:

_____

Allergic Reactions: _____

Patient educated about: ***Lasik*** ***PRK*** ***RLE*** ***RLI*** ***CATARACTS***

Please check if: _____**Patient needs to return to Optometrist office for a pre-op exam prior to surgery**.

Dr's Sig: _____