Oculoplastics Co-management Referral Form

Please fax or e-mail to:

GORDON SCHANZLIN
NEW VISION INSTITUTE

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Referring Doctor______________________________ Phone________________ Date_______________

Referring to: Jean Paul Abboud, MD, PhD

Patient Name: ____ DOB_____________________

Address:____

Phone: Home______________________________________ Cell___________________________________

E-mail:____ Occupation:___________________________

Reason for considering surgery/ expectations/ comments:_____________________________________

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Pre-Procedure Information

	Right	***Left***
Vision		
Recent Visual Field (if done)	Y or N	Y or N

Ocular History: ____

Medical History:

____

Allergic Reactions:

____

OD discussed with patient: ____

Dr's Sig: ____