BRAVERMAN - TERRY - OEI
EYE ASSOCIATES
EXCELLENCE IN EYE CARE

Referral Form

1100 N Main, San Antonio, TX 78212

Main phone: (210) 222-2154 Office fax: (210) 225-2424

Patient Name:

Patient Insurance:

Relationship:

ID Number:

Date of Request:

Patient DOB:

Patient Phone:

Insurance Phone:

Doctor Requested (circle one): Dr. Alsheikh, Dr. Friedman, Dr. Ku, Dr. Oei, First Available

Reason for Consult (check all that applies):

- Sudden Loss of Vision (Emergent consult)
- Eye pain
- Cataract
- Ulcer
- LASIK/PRK
- Corneal crosslinking (keratoconus)
- ICL
- Glaucoma
- Diabetic Retinopathy
- Retinal Detachment
- Macular Hole/Epiretinal membrane
- Uveitis
- Neuro (Double Vision/ MS etc.)
- Other:

Referring Doctor:

Office Name:

Office Location:

Office Phone:

Office Fax:

Comments:

Please Specify Time Frame:

- Immediate Consult (Today)
- 1-2 days
- 1-2 weeks
- Next Available

Manifest

OD ____________ VA ______

OS ____________ VA ______

If referring for cataract surgery, will the patient be comanaged?

- yes
- no

Fax Completed Form to: (210) 227-6056