



Orlando Eye Specialists

Javier Pérez, MD, FACS

*Board Certified Ophthalmologist
Glaucoma and Cataract Specialist*

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Consultation Referral Form

Referring Doctor: _____ Date: _____

Phone: _____ Fax: _____

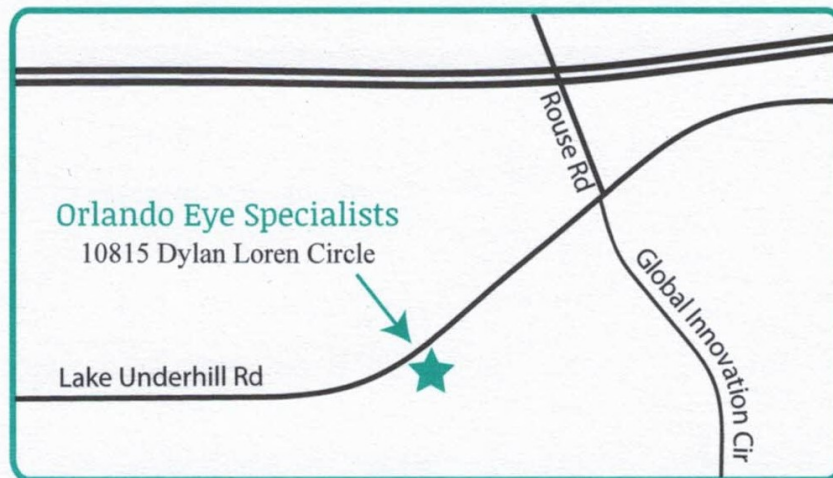
Patient's Name: _____

Phone: _____ D.O.B. _____

Indication for Consult:

- | | |
|--|---|
| <input type="checkbox"/> Surgical Consultation | <input type="checkbox"/> Blurry or Decreased Vision |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Irritation / Discomfort |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dry Eyes / Allergies |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Visual Disturbance |

Notes: _____



To our patients:

Please bring this form with you to your appointment.
Please notify us if you are unable to keep your appointment.

www.orlandoeyespecialists.com