



Berks Eye

Physicians & Surgeons, Ltd.

Hours: Monday & Thursday: 8:00 am - 7:00 pm; Tuesday, Wednesday & Friday: 8:00 am - 5:00 pm

Phone: 610-372-0712

# Optometrist Referral to Ophthalmologist

Today's Date: \_\_\_\_\_ Referring OD: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Berks Eye MD Requested:  Izzo  Calder  Tellez  Bronner  Pierson  Any

Primary Insurance \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Cataract Evaluation  Glaucoma Evaluation  Retinal Evaluation  Corneal Evaluation

Other: \_\_\_\_\_

Most Recent Rx: OD: \_\_\_\_\_ OS: \_\_\_\_\_

Does patient wear contacts?  Yes  No What kind? \_\_\_\_\_

Ocular Medications: \_\_\_\_\_

Is there a family history of glaucoma?  Yes  No Who? \_\_\_\_\_

Current IOP: OD: \_\_\_\_\_ OS: \_\_\_\_\_ Tmax: OD: \_\_\_\_\_ OS: \_\_\_\_\_

History of ocular surgery: \_\_\_\_\_

Please describe reason for referral: \_\_\_\_\_

**Thank you for your referral**  
Please fax this form to Berks Eye at 610-376-6968