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