

OCULOPLASTIC REFERRAL FORM



REFERRING TO:

Date: _____

• **Daniel B. Lensink, MD**
Fax# 530-229-3945

Siskiyou Eye Surgeon
Fax# 541-488-5081

COMANAGING DOCTOR _____

REFERRING LOCATION _____ Patient to be seen at: **Ashland Location**

PATIENT: Last Name _____ First Name _____ MI _____

Address _____

Phone Number _____ Date of Birth _____

PLEASE SEND THE PATIENT'S REGISTRATION INFORMATION WITH THIS FORM

REFERRING DIAGNOSES AND/OR TREATMENTS

LID

- | | | |
|----------------------------|-------------------|--------------------------------|
| • Blepharoplasty-lower | Cosmetic Consult | Lid Retraction |
| • Blepharoplasty-upper | Dermatochalasis | Neoplasm, benign |
| • Blapharospasm | Ectopion | (incl. chalazion, cysts, etc.) |
| • Botox | Entropion | Neoplasm, poss. Malignant |
| • Brow Ptosis | Hemifacial Spasm | Ptosis |
| • Chalazion | Lagophthalmos | Skin Cancer |
| • Chemodenervation (Botox) | Laser Resurfacing | Other _____ |

LACRIMAL / TEARING

- | | | |
|-------------------------|-----------------------|-------------|
| • Canaliculitis | Probing Irrigation | Other _____ |
| • Dacryocystitis | Tear Duct Obstruction | |
| • Dacryosystorhinostomy | Tearing Evaluation | |

ORBIT

- | | | |
|----------------|---------------------|-------|
| • Cellulitis | Graves' Eye Disease | Tumor |
| • Exophthalmus | Proptosis | Other |
| • Fracture | | |

COMMENTS _____
