

# OCULOPLASTIC REFERRAL FORM



SISKIYOU  
EYE  
CENTER

Fax completed form to Siskiyou Eye Center  
Ashland: 541-488-5081

REFERRING TO:

Date: \_\_\_\_\_

Daniel B. Lensink, MD

Siskiyou Eye Surgeon

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Blepharoplasty-lower     | <input type="checkbox"/> Cosmetic Consult  | <input type="checkbox"/> Lid Retraction                                     |
| <input type="checkbox"/> Blepharoplasty-upper     | <input type="checkbox"/> Dermatochalasis   | <input type="checkbox"/> Neoplasm, benign<br>(incl. chalazion, cysts, etc.) |
| <input type="checkbox"/> Blapharospasm            | <input type="checkbox"/> Ectopion          | <input type="checkbox"/> Neoplasm, poss. Malignant                          |
| <input type="checkbox"/> Botox                    | <input type="checkbox"/> Entropion         | <input type="checkbox"/> Ptosis   |
| <input type="checkbox"/> Brow Ptosis              | <input type="checkbox"/> Hemifacial Spasm  | <input type="checkbox"/> Skin Cancer  |
| <input type="checkbox"/> Chalazion                | <input type="checkbox"/> Lagophthalmos     | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Chemodenervation (Botox) | <input type="checkbox"/> Laser Resurfacing |   |

### LACRIMAL / TEARING

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Canaliculitis         | <input type="checkbox"/> Probing Irrigation    | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dacryocystitis        | <input type="checkbox"/> Tear Duct Obstruction |                                      |
| <input type="checkbox"/> Dacryosystorhinostomy | <input type="checkbox"/> Tearing Evaluation    |                                      |

### ORBIT

- |                                       |  |                                |
|---------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Cellulitis   | <input type="checkbox"/> Graves' Eye Disease | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Exophthalmus | <input type="checkbox"/> Proptosis           | <input type="checkbox"/> Other |
| <input type="checkbox"/> Fracture     |  |                                |

COMMENTS \_\_\_\_\_

\_\_\_\_\_