Referral Form

Berkeley School of Optometry

Digital Health	☐	Refractive Surgery	☐
Dry Eye Clinic	☐	Sjögren's Clinic	☐
Infant and Toddler Care	☐	Specialty Contact Lens Clinic	☐
Low Vision Clinic	☐	Special Visual Assessment	☐
Myopia Control Clinic	☐	Sports Vision Clinic	☐
Neuro-Evals (BV)	☐	Vision Functions	☐
Ocular Disease	☐	Vision Therapy & Rehabilitation (BV)	☐

Please fax or email this referral form to us at:

(510) 642-8012

caleyecare@berkeley.edu

Date:

Referred to Provider (Optional):

PATIENT INFORMATION

Patient's First Name: Last Name:

DOB: Gender:

Home Phone: Cell Phone:

Interpreter Needed: ☐ Yes ☐ No Language:

Parent/Guardian: Relationship to Patient:

Email:

Address:

City: State: Zip:

CONSULTATION REQUEST INFORMATION

Diagnosis: ICD 10:

Reason for Referral:

Include brief pertinent medical records that support the consultation: ☐ Clinical notes ☐ Imaging ☐ Labs

REFERRER'S INFORMATION

First and Last Name: Job Title/Specialty:

Phone: Fax:

Practice/Hospital/Place of Work:

Address:

City: State: Zip:

PCP INFORMATION

PCP Name: Phone:

INSURANCE INFORMATION (Optional)

☐ Medical Insurance ☐ Vision Insurance

Subscriber Name: DOB:

Health Plan: Member ID:

Group #: Authorization #:

Secondary Insurance, if any:

By providing the information requested and signing above, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.