

# ★ Referral Request



**T O** AYAD A. FARJO, M.D.  
 QAIS A. FARJO, M.D.  
 KARIN R. SLETTEN, M.D.

DATE: \_\_\_\_\_

- CONSULTATION AND TREATMENT  
 CONSULTATION ONLY

PATIENT NAME: \_\_\_\_\_

PATIENT D.O.B.: \_\_\_\_\_ PATIENT PHONE NUMBER: \_\_\_\_\_

REFERRING PHYSICIAN / OPTOMETRIST: \_\_\_\_\_

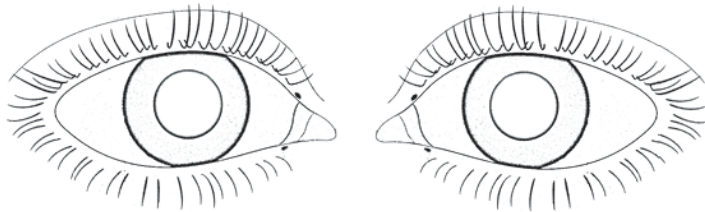
REFERRING PHYSICIAN / OPTOMETRIST PHONE NUMBER: \_\_\_\_\_

**REASON FOR CONSULTATION:**

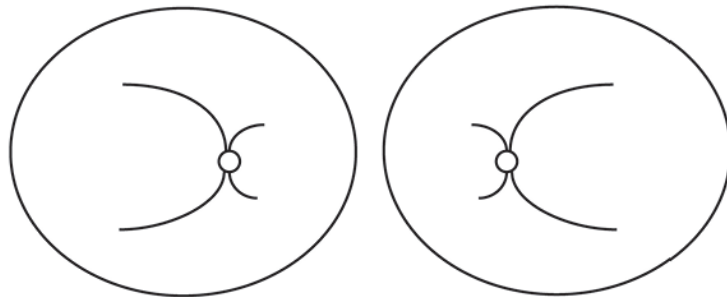
\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- CATARACT / IOL       CORNEA  
 LASIK / INTRALASIK       RETINA  
 DIABETES       IRIS  
 GLAUCOMA       TRAUMA

- WILLING TO PARTICIPATE  
 IN POST-OPERATIVE CARE

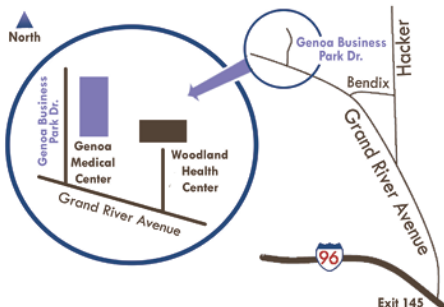


- APPOINTMENT REQUESTED:**  URGENT  
 3-6 DAYS  
 1-2 WEEKS



**TESTS REQUESTED:**

- FLUORESCEIN ANGIOGRAPHY  
 PENTACAM / TOPOGRAPHY  
 OCT       VISUAL FIELD  
 GONIOSCOPY       IOLMASTER  
 PACHYMETRY       A-SCAN



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