CAI RETINA
Specialty Eye Care

Louis Cai, MD
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Patient Referral Form

Name*_____Date _____

Patient Email _____

Patient Phone* _____ DOB _____

Insurance _____Member ID_____

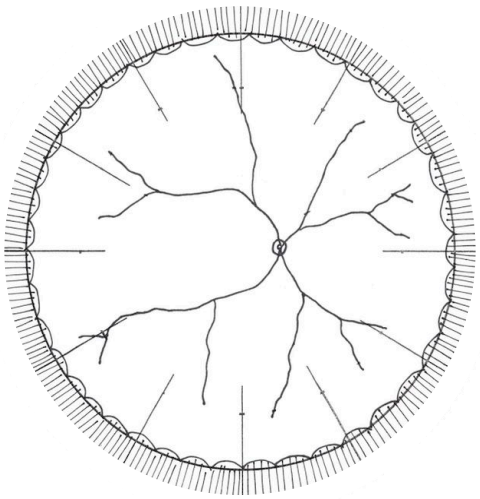
Visual Acuity: Right Eye 20/_____ Left Eye 20/_____

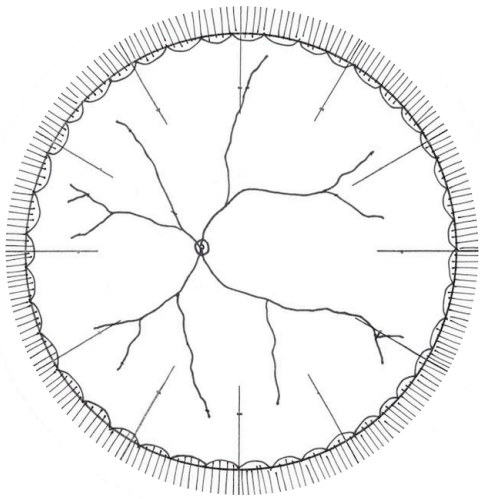
Appointment: ☐ ASAP (Call 408-540-3559) ☐ Within 1 Week ☐ Non-urgent

Referring Doctor _____ Phone _____

Consultation for:

☐ Wet AMD or CNV (R/L) ___
☐ Dry AMD (R/L) ___
☐ Epiretinal membrane (R/L) ____
☐ Diabetic Retinopathy (R/L) ____
☐ Macular Edema (R/L) ____
☐ PVD/Flashes/Floaters (R/L) ____
☐ Retinal Tear (R/L) ____
☐ Retinal Detachment (R/L) ____
☐ Retinal Lesion (R/L) ____
☐ Retinal Vein Occlusion (R/L) ____
☐ Uveitis/Iritis (R/L) ____
☐ Other _____





Fax to: 408-418-2803 or use the secure upload link (Ctrl + Click)