



615 Piikoi St., # 205, Honolulu, HI 96814 Ph: 808-591-9911 ♦ Fax: 808-591-9909

### CATARACT REFERRAL RECORD

\_\_\_\_\_  
Date *Patient's Name* *DOB*

\_\_\_\_\_  
Referred By *Address*

\_\_\_\_\_  
Address *City, State, Zip*

\_\_\_\_\_  
Phone *Home Phone* *Work Phone*

Reason(s) for Referral: \_\_\_\_\_

Pertinent Symptoms, History: \_\_\_\_\_

Results of Examination:

Rx: OD \_\_\_\_\_ BCVA \_\_\_\_\_

OS \_\_\_\_\_ BCVA \_\_\_\_\_

Tonometry / \_\_\_\_\_ (method) Time: OD \_\_\_\_\_ OS \_\_\_\_\_

Pupil Sizes (bright/dim illum): OD \_\_\_\_\_ mm / \_\_\_\_\_ mm OS \_\_\_\_\_ mm / \_\_\_\_\_ mm

Other Pertinent Results of Examination: \_\_\_\_\_

Procedures Requested: \_\_\_\_\_

\_\_\_\_\_  
Referring Doctor's Signature

**Co-manage?** Yes / No  
(if yes, patient sign co-management consent?)