Laser Vision Clinic
Central Coast

REFERRAL TO LASER VISION CLINIC CENTRAL COAST

Patient details:

Name____ DOB___________

Thank you for seeing this patient for:

- ☐ Assessment for laser refractive surgery (LASIK, ASLA)
- ☐ Assessment for phototherapeutic keratectomy (PTK)
- ☐ Pentacam corneal topography and/or wavefront analysis
- ☐ Other

Clinical Details / Comments

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Refraction (if appropriate)

OD___________/________________ OS__________/_________________

Add +_________________ Add +__________________

Referring Practitioner: ____

Provider number: ____

☐ Please send me more referral pads:

Signature _________________________ **Date**_____________

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