HORIZON EYE SPECIALISTS & LASIK CENTER

**Consultation Request**
Main: 602-HORIZON (602-467-4966)

**Patient Name:**_____ **DOB:**_____ **Phone:**_____ **Date:**_____
**Insurance:**_____ **E-mail:**_____

**Referring Doctor Information: Name:**_____ **Phone:**_____
**Address:**_____ **Fax:**_____ **E-mail:**_____

**Please check one**:
☐ The patient has a consultation scheduled on: _____ ☐ Please call the patient to schedule

**The above patient is being referred for consultation regarding:**

☐ Cataract ☐ Secondary cataract ☐ Cornea ☐ Glaucoma/glaucoma suspect
☐ Retina ☐ LASIK/Refractive surgery ☐ Other _____

**BCVA: OD:** 20/__ **OS:** 20/__ **Most Recent Rx: OD**: _____ **OS**: _____

**IOP: OD:**___ **OS:**___ **Goldman NCT Tonopen**
**Time:** __:__ **AM/PM**

Additional information and/or pertinent findings:
_____
_____

**Please choose the office location the patient prefers:**

☐ **Scottsdale:** 18325 N. Allied Way, Suite 100, Phoenix, AZ 85054
☐ **Peoria:** 16150 N. Arrowhead Ftns. Ctr. Dr., Suite 150, Peoria, AZ 85382
☐ **Desert Ridge**: 20940 N. Tatum Blvd., Suite 370, Phoenix, AZ 85050
☐ **West Phoenix:** 9515 W. Camelback Rd., Suite 110, Phoenix, AZ 85037
☐ **Goodyear**: 740 N. Estrella Pkwy, Suite 110, Goodyear, AZ 85338
☐ **Central**: 2020 N. Central Ave., Suite 1110, Phoenix, AZ 85004
☐ **Sun City:** 10615 W. Thunderbird Blvd., D180, Sun City, AZ 85351
☐ **West Valley**: 2580 N. Litchfield Rd., Goodyear, AZ 85395

**If you would like to refer to a particular physician, please select:**

☐ Robert McCulloch, M.D. ☐ Jonathan Levin, M.D. ☐ Angela Kovacik (Herro), M.D.
☐ Joshua Duncan, D.O. ☐ Sara Ghobraiel, M.D. ☐ John Cason, M.D.
☐ Other _____

☐ **First Available Appointment (any physician)**

**Please check one**:
☐ **Referring** (patient to be returned when treatment is complete)
☐ **Co-Managing** (referring doctor will be responsible for follow up care and must be a provider of the patients medical insurance if other than refractive surgery only)

## TO BE COMPLETED BY THE PATIENT: *ELECTION OF POSTOPERATIVE CARE PROVIDER*

I understand that I may elect to have my postoperative care performed by the optometrists at Horizon Eye Specialists and LASIK Center or by another eye doctor. If I choose to have my follow-up examinations performed by another eye doctor I must notify Horizon Eye Specialists and LASIK Center when I schedule surgery so that payment can be apportioned appropriately. I understand that if I choose to receive my follow-up care outside Horizon Eye Specialists and LASIK Center the transfer of such care will only occur if and when it is medically appropriate, and my surgeon releases me.

In transferring my follow-up care I realize that it becomes the responsibility of the doctor I have chosen to provide Horizon Eye Specialists and LASIK Center with information concerning my post-operative status. I understand that if my local eye doctor identifies a complication I may be required to return to a Horizon Eye Specialists and LASIK Center physician at any time. Also, I may choose to return for any reason of concern I may have.

☐ I elect to have my local eye doctor, Dr._____ examine me postoperatively and I authorize this doctor to release copies of my treatment exams to Horizon Eye Specialists and LASIK Center during my:

☐ Cataract 90 day postoperative period ☐ LASIK 1 year postoperative period ☐ Other_____

☐ I elect to return to Horizon Eye Specialists and LASIK Center for my postoperative care.

Patient Signature: _____ Date: _____

# FAX THIS FORM TO 480-419-5472