



## Referral for Oculoplastic Consultation

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_

### Referred for

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Dermatochalasis/Ptosis | <input type="checkbox"/> Chalazion           | <input type="checkbox"/> Cellulitis       |
| <input type="checkbox"/> Ectropion              | <input type="checkbox"/> Lacrimal/tearing    | <input type="checkbox"/> Cosmetic Consult |
| <input type="checkbox"/> Entropion              | <input type="checkbox"/> Thyroid Eye Disease | <input type="checkbox"/> Botox            |
| <input type="checkbox"/> Eyelid/Face Lesions    | <input type="checkbox"/> Trauma              | <input type="checkbox"/> Dermal Filler    |
| <input type="checkbox"/> Conjunctival Lesion    | <input type="checkbox"/> Blepharospasm       | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Pterygium              |  |   |

Comments: \_\_\_\_\_

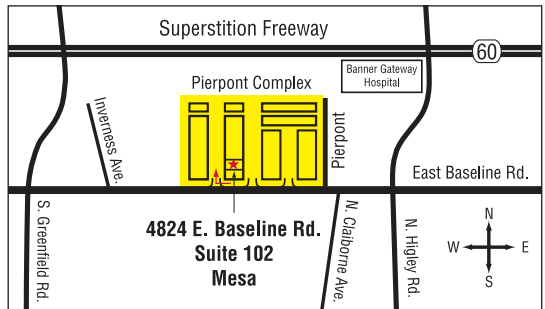
### Appointment Arrangements

- Appointment was made for the patient:

Date \_\_\_\_\_

Time \_\_\_\_\_

- Patient will call Dr. Ghafouri's office to schedule an appointment at 480-905-1010
- Please have Dr. Ghafouri's office call the patient to schedule an appointment
- Referral form faxed to 480-905-6988



For directions to our office please visit our website  
[www.eyelidsurgeries.com](http://www.eyelidsurgeries.com)

**Patient will return to referring doctor for continuing care.**

**Please bring this form with you to your appointment.**