OCULOPLASTIC REFERRAL FORM

FAX
SISKIYOU EYE CENTER

REFERRING TO: Date:_____

ÿ **Daniel B. Lensink, MD** **Siskiyou Eye Surgeon**
Fax# 530-229-3945 **Fax# 541-488-5081**

COMANAGING DOCTOR_____

REFERRING LOCATION_____ Patient to be seen at: **Ashland Location**

PATIENT: Last Name_____ First Name_____ MI____

Address_____

Phone Number_____ Date of Birth_____

PLEASE SEND THE PATIENT'S REGISTRATION INFORMATION WITH THIS FORM

REFERRING DIAGNOSES AND/OR TREATMENTS

LID

ÿ	Blepharoplasty-lower	Cosmetic Consult	Lid Retraction
ÿ	Blepharoplasty-upper	Dermatochalasis	Neoplasm, benign
ÿ	Blapharospasm	Ectopion	(incl. chalazion, cysts, etc.)
ÿ	Botox	Entropion	Neoplasm, poss. Malignant
ÿ	Brow Ptosis	Hemifacial Spasm	Ptosis
ÿ	Chalazion	Lagophthalmos	Skin Cancer
ÿ	Chemodenervation (Botox)	Laser Resurfacing	Other_____

LACRIMAL / TEARING

ÿ	Canaliculitis	Probing Irrigation	Other_____
ÿ	Dacryocysitis	Tear Duct Obstruction	
ÿ	Dacryosystorhinostomy	Tearing Evaluation	

ORBIT

ÿ	Cellulitis	Graves' Eye Disease	Tumor
ÿ	Exophthalmus	Proptosis	Other
ÿ	Fracture		

COMMENTS_____

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