

Kevin H. Cuevas, M.D
14142 Denver West Parkway, Building 51, Suite 285
Lakewood, CO 80401
(303) 384-3700 Telephone
(303) 384-3855 Fax

REFERRAL FORM

Date: _____ Patient Name: _____

Referred By: _____ Patient Phone: _____

Doctor's Phone: _____ Insurance: _____

Doctor's Fax: _____ Additional Info: _____

Reason for referral (please circle):

Blepharoplasty Clear Lensectomy Dry Eye Syndrome Eyelid Lesion Pterygium
Chalazion Cataract Eval Presbyopia-Correcting IOL Verisyse Phakic IOL Corneal Eval
Epiphora Glaucoma Eval Yag Capsulotomy

History: _____

MANIFEST OD _____ VA _____
REFRACTION OS _____ VA _____

Anterior Segment:

Posterior Segment:

Comments: _____

This patient would like to be co-managed with the referring optometrist's office
after cataract surgery: ____yes ____no

**Thank you for your referral. We will contact your patient the day we receive
your fax to schedule an appointment.**