

FAMILY VISION CARE REFERRAL/CONSULTATION REQUEST AND RESPONSE FORM

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PATIENT NAME: _____ PHONE: (____) _____

D.O.B.: _____ PARENTS' NAME(S): _____

FORMS GIVEN TO PATIENT TO COMPLETE AND BRING TO OUR OFFICE? YES / NO

WHEN DOES PATIENT NEED TO BE SEEN? WITHIN _____ DAY(S) _____ WEEK(S)

PART A: TO BE COMPLETED BY REFERRING DOCTOR

Date of examination: _____

Reason for referral and pertinent history:

Current glasses prescription (if applicable):

OD: _____ - _____ X _____ 20/ _____

OS: _____ - _____ X _____ 20/ _____

NAME OF REFERRING DOCTOR

P: (____) _____ F: (____) _____
ADDRESS & PHONE/FAX NUMBER FOR REFERRING DOCTOR

PART B: COMPLETED EVALUATION/REPORT BY FAMILY VISION CARE DOCTOR

Date of examination: _____

Pertinent examination findings:

Treatment plan:

Thank you for trusting us in the care of your patients.

GARY SNEAG, O.D, FCOVD / JENNIFER N. TAM, O.D., FAAO

FULL CONSULTATION REPORT AVAILABLE UPON REQUEST