Capital Eye
Medical Group

Mitra Ayazifar, MD

PATIENT REFERRAL

DATE:_____

Please send completed form with all relevant chart notes, demographics, insurance cards, images & test results to (530) 298-9223 or email INFO@CAPEYEMED.COM

***Patient name:**_____

***DOB:**_____ ***Phone Number:**_____

Email:_____

***Insurance:**_____ ***Medical Group:**_____

Authorization:_____

***Referring Doctor:**_____

***Office Name & Number:**_____

***CO-MANAGEMENT ACKNOWLEDGMENT: PLEASE FILL OUT FOR EVERY REFERRAL**

☐ **YES -** I'd like to co-manage the patient's post-op care if surgery is recommended and is medically appropriate.
I accept the patient's medical insurance: ☐ Yes ☐ No
If recommended, I will co-manage MIGS: ☐ Yes ☐ No

☐ **NO -** I do NOT wish to co-manage the patient's post-op care, if surgery is recommended, I'd prefer Capital Eye Medical Group to assume the patient's post-op care and I will resume the general care of the patient after the post-op period.

☐ **Cataract Evaluation**
CPT Codes: 92004, 99202, 92082, 92134, 92136, 76519
Previous LASIK/PRK ☐ Yes ☐ No

☐ **Glaucoma Evaluation**
CPT Codes: 92004, 99202-99205, 92020, 92082, 92083, 92133, 76514
☐

☐ **Eyelid Consultation:**
☐ Cosmetic eyelid surgery
☐ Functional eyelid surgery

COMMENTS/OTHER: