Aker Kasten Eye Center

Alan B. Aker, MD
Ann Kasten Aker, MD
Anup Kubal, MD
Vito J. Guario, OD
Kelli Wolper, OD
Alexis Seidel, OD

REFERRAL
to Aker Kasten Eye Center

Date: _____

REFERRING DOCTOR: _____ **Phone #:** _____

Referred To: ☐ Alan Aker, MD ☐ Anup Kubal, MD

Patient Name: _____ **Phone #:** _____

Reason for Referral:

☐ Cataract Consultation ☐ Call patient to schedule

☐ _____

CATARACT REFERRALS

☐ Ready for Cataract Surgery ☐ OD ☐ OS ☐ OU

Based on my findings and discussion with the patient, I am recommending the patient consider the following:

☐ Toric IOL ☐ Premium IOL ☐ Femto ☐ Standard IOL

Co-Managed Patients:

My doctor has discussed the potential options with me for cataract surgery, including the Femtosecond Laser and Premium lenses.

I have received a copy of this report and will bring it with me to my appointment at Aker Kasten Eye Center.

I understand that my own eye doctor will manage my post-operative care.

Patient Signature: _____

COMPLETED REPORT: 1) Provide a copy to your patient to bring to appointment
2) FAX REPORT TO (561) 980-7711