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

Aker Kasten Eye Center

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

Please check all that apply:

Discussed	Interested	
☐	☐	**TORIC LENS**
☐	☐	**PREMIUM LENS**
☐	☐	**FEMTOSECOND LASER ASSISTED CATARACT SURGERY**

☐ Ready for Cataract Surgery ☐ OS ☐ OD ☐ OU

Based on my findings and discussion with the patient, I am recommending the patient be considered for the following:

☐ Toric IOL ☐ Premium IOL ☐ Femto ☐ Standard IOL

PLEASE FAX REPORT TO: 561-338-7785