The TOTAL EYE CARE TEAM

LOUISIANA EYE & LASER

231 Windermere Boulevard, Alexandria, LA 71303
Phone: 318.487.2020 | Toll Free: 1.877.861.7770

PLEASE FAX REFERRAL FORM TO: 318-427-0170

DATE: _____

PATIENT NAME: _____ **PATIENT DOB:** _____

PATIENT INSURANCE: _____ **PATIENT PHONE:** _____

REFERRAL DOCTOR: _____ **DOCTOR PHONE:** _____

*** **Please include a copy of the patient's demographics** ***
*** **and last clinic note with the referral form** ***

DIAGNOSIS/REASON FOR REFFERAL:

Cataract:	___	Retina (Diabetic/Plaquenil) Other:	___
LASIK:	___	Dry Eye:	___
Lids:	___	Glaucoma:	___

Other: _____

ADDITIONAL NOTES/COMMENTS: _____

_____

_____

_____

_____

Requested Doctor (if any): _____