Paul T. Finger, MD

REFERRAL PAD

Referring Physician:

Name: _____

E-mail address: _____ Preferred [ ]

Telephone number: _____ Preferred [ ]

Patient:

Name: _____

E-mail address: _____ Preferred [ ]

Telephone number: _____ Preferred [ ]

Diagnosis: _____

Date of Referral: _____

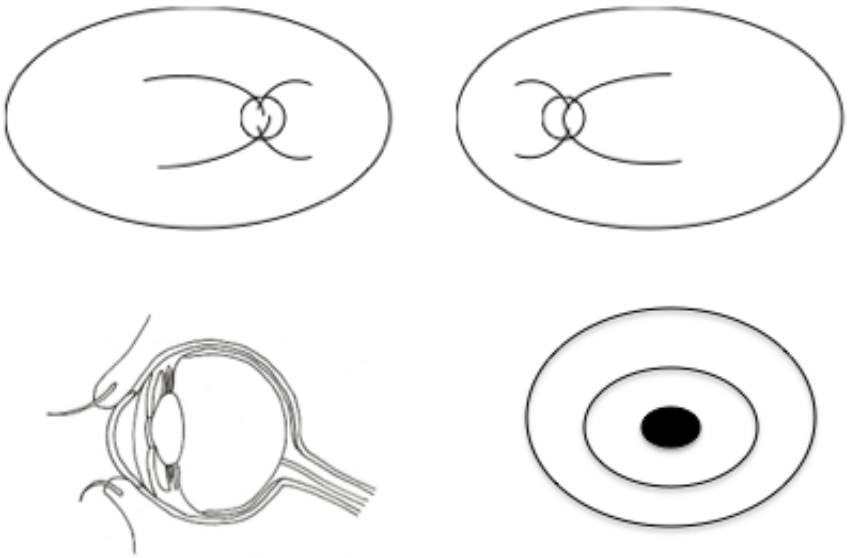
Ophthalmic Oncology Consultation (Check)

____ Eyelid or Conjunctival Tumor ____ Orbital Tumor

____ Anterior Segment Tumor ____ Posterior Segment Tumor

____ Diagnosis only ____ Diagnosis and Treatment

[ ] Right Eye [ ] Left Eye



NEW YORK EYE CANCER CENTER

SAVING SIGHT • SAVING LIVES

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