



**Paul T. Finger, MD**

# REFERRAL PAD

## Referring Physician:

Name: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Preferred [ ]

Telephone number: \_\_\_\_\_ Preferred [ ]

## Patient:

Name: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Preferred [ ]

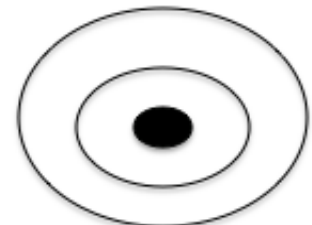
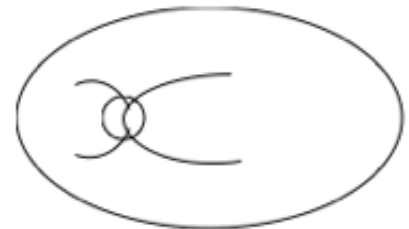
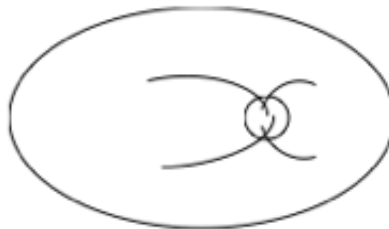
Telephone number: \_\_\_\_\_ Preferred [ ]

**Diagnosis:** \_\_\_\_\_

**Date of Referral:** \_\_\_\_\_

## Ophthalmic Oncology Consultation (Check)

- |   |  |
|---|--|
| <input type="checkbox"/> Eyelid or Conjunctival Tumor | <input type="checkbox"/> Orbital Tumor           |
| <input type="checkbox"/> Anterior Segment Tumor       | <input type="checkbox"/> Posterior Segment Tumor |
| <input type="checkbox"/> Diagnosis only               | <input type="checkbox"/> Diagnosis and Treatment |
| [ ] Right Eye [ ] Left Eye                            |  |



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EYE CANCER CENTER**

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