FAX Coversheet for Vision Examination

Please fill out to improve patient's Health Care

To: Facey Medical Group **Fax#** 818-729-5842

Eye provider name: **Eye provider phone#:**

Eye provider signature:

Date of Eye Examination: ____/____/ 21

☐ **Optometrist**

☐ **Ophthalmologist**

Patient Name:

DOB: **Gender:**

Patient PCP:

☐ No Diabetic Retinopathy	☐ Diabetic Retinopathy Detected

Comments/Notes:

Fax Disclosure Information

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Facey Medical Group

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