COASTALVISION
Technique. Technology. Trust.

Phone (888) 501-4496

Fax (714) 771-7126

☐ **Chino/Chino Hills**
14726 Ramona Ave., #200
Chino, CA 91710

☐ **Long Beach**
4300 Long Beach Blvd., #400
Long Beach, CA 90807

☐ **Orange**
363 S. Main St., #325
Orange, CA 92868

☐ **Irvine**
15825 Laguna Canyon Rd.,
#201 Irvine, CA 92618

Select a Provider:
☐ Dan B. Tran, MD
☐ Amir H. Marvasti, M.D
☐ Betsy Nguyen, MD
☐ Abinaya Thenappan, MD
☐ Optometrist
☐ First Available

Consultation Request Form

Patient Name: _____ ☐ Male ☐ Female **DOB:** _____ **Today's Date:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Email Address:** _____

Type of Insurance:
☐ HMO
☐ PPO
☐ Medicare

Type of Consultation:
☐ LASIK/PRK ☐ Cataract ☐ RLE ☐ EVO ICL ☐ SMILE Pro
☐ Glaucoma ☐ Glaucoma Screening ☐ SLT (Laser) ☐ Dry Eye ☐ Pterygium
☐ Cornea ☐ Corneal Crosslinking ☐ FDA Clinical Trial ☐ Other:_____

UCVA:	Current Refraction	BCVA:
OD: 20/_____	OD: _____.____x_____ ADD:_____	OD: 20/_____
OS: 20/_____	OS: _____.____x_____ ADD:_____	OS: 20/_____

Options Discussed:
☐ Monofocal IOL
☐ Toric IOL
☐ Multifocal IOL
☐ Light Adjustable Lens
☐ Laser Assisted Surgery
☐ ORA
☐ MIGS (Interventional Glaucoma)
☐ LASIK
☐ SMILE Pro
☐ EVO ICL
☐ PRK
☐ Custom Lens Replacement

Rx Stable Since: _____
Previous Refractive Surgery: ☐ YES ☐ NO
Discussed Monovision: ☐ YES ☐ NO
Eye Dominance: ☐ OD ☐ OS
Target: OD_____ OS_____
TBUT: OD_____ OS_____

Co-Managing Doctor Information

Doctor Name: _____ **City:** _____

Phone Number: _____ **Fax Number:** _____ **Email:** _____

Recommendations/Comments: _____

_____

Fee Quoted: _____ **Coastal Vision Representative:** _____

☐ **I desire to co-manage this patient, and will be responsible for my portion of the patient's post-operative care when the patient is referred back to me, including:**

☐ Punctal Plugs ☐ Dry Eye Management ☐ Glaucoma Management ☐ Medicare 90-Day Post-Operative Period
☐ Receive pre/post-op services payment through CoFi. ☐ I need to get setup on CoFi.
☐ Collect pre/post-op services payment at our practice.

Doctor's Signature:_____ **Date:**_____

Consult Fax Line: (714) 771-7126 or (951) 479-5817
Digital Line Analog Line