Vision Correction Surgery
Cornea & Anterior Segment Disease
Cataract & Implant Surgery
General Ophthalmology

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☐ Paul C. Kang, M.D.

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Glaucoma
Cataract Surgery
Anterior Segment Laser Treatment
General Ophthalmology

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Pediatric Eye Care
Adult Strabismus

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Oculoplastic
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Request for Consultation

(Please Print)

Patient's Name: _____

Date: _____

Referring Doctor's Name: _____
(Please Print)

Referring Doctor's Phone Number & Practice: _____

_____

Dear Eye Doctors of Washington:

I am sending this patient to you for assistance with his/her care. Please evaluate this patient's or condition(s) and consider treatment as appropriate.

_____

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_____

I look forward to receiving your opinion and advice regarding care of this patient, and will resume general care following your consultation.

Signed: _____
(Referring Doctor)

Ask the patient to call our office to schedule an appointment, referencing the referral and this form on the day of appointment. Please fax this form to 240-482-3070 in advance of the patient's scheduled appointment. Thank you.