**Referring Doctor:**_____

Date of referral:_____

**Patient Name:** _____

**Patient DOB:** _____

**Phone Number:** _____ Alt #: _____

Other Information: _____

_____

_____

_____

_____

## Reason for Referral

☐ Cataract ☐ Glaucoma ☐ Diabetic ☐ Retina ☐ Lid ☐ LASIK

## Doctor

☐ Dr. Langley ☐ Dr. Dyer ☐ Dr. Williams ☐ Dr. Bull

***Thank you for letting us be your referral choice!***

EyeCare Associates of South Tulsa | TLC Laser Eye Centers®

Phone: 918.250.2020 **FAX TO: 918.893.9246**

*please fill out form completely*