Patient Referral Form

HOPE
CATARACT & LASER

OMAR KRAD, MD
Board-Certified Cataract and Refractive Surgeon
DEDICATED CONSULT FAX LINE (530) 237-1551

Referring Doctor

Date _____

Referred by _____

Office Phone _____ Office Fax _____

Patient Information

Patient Name _____

Patient Tel _____

Patient Email (if preferred) _____

Reason for Consult

☐ Cataract Surgery	☐ PCO / Yag Caps	☐ Flashes / Floaters
☐ RLE	☐ Glaucoma	☐ Retinal Tear / Detachment
☐ IOL Exchange	☐ Pterygium	☐ Macular Degeneration
☐ LASIK / EVO ICL	☐ Diabetes / HTN	☐ Other _____

Follow-Up Date

☐ **Emergent** ☐ **Within 1 week** ☐ **Next Available**

1400 N. Harbor Blvd, Suite 100
Fullerton, CA 92835
Tel (714) 879-0020

South OC Location
Opening Late 2026

Dear patient, please bring this form with you to your appointment. Thank you!