# Consultation Referral Form

Eye Center of NEW YORK

**Tal Raviv** MD, FACS

*Board Certified Cataract & Refractive Surgeon*
*Clinical Associate Professor of Ophthalmology*
*Icahn School of Medicine at Mount Sinai*
*New York Eye and Ear Infirmary of Mount Sinai*
*Founder and Medical Director, Eye Center of New York*

**Dan Davis** OD

*Vice President of Clinical Affairs*
*Eye Center of New York*

## Referring Doctor

Date _____

Referred by _____

Office Phone _____ Office Fax _____

## Patient Information

Patient Name _____

Patient Tel _____

Patient Email (if preferred) _____

## Please Consult for

- ☐ **Cataract Surgery**
- ☐ **Glaucoma** _____
- ☐ **LASIK**
- ☐ **Diabetes / HTN** _____
- ☐ **Dry Eye**
- ☐ **Other** _____

## Office Location Info

30 East 40th Street, Suite 203
New York, NY 10016

212-889-3550
212-696-1190 (Fax)

info@EyeCenterOfNY.com
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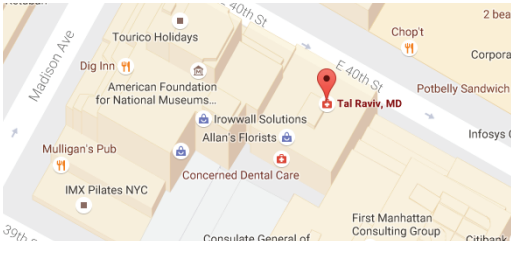


Dear patient, please bring this form with you on your appointment.