DRS. CAMPBELL CUNNINGHAM
TAYLOR & HAUN

1124 E WEISGARBER RD, STE 106
KNOXVILLE, TN 37909
PHONE: (865) 588-3937, press option 1 FAX: (865) 588-7673
EMAIL: rdotson@ccteyes.com or physicianreferrals@ccteyes.com

PATIENT NAME:_____ DOB:_____

PATIENT ADDRESS: _____

_____

PATIENT PHONE:_____ CELL / HOME

PATIENT EMAIL:_____

REFERRING DOCTOR:_____

OFFICE ADDRESS:_____

PHONE:_____ FAX:_____

PLEASE CIRCLE ALL THAT APPLY:

CATARACT LASIK CORNEA RETINA OTHER

I am sending this patient to Dr._____ for evaluation for refractive surgery and consider treatment as appropriate. I would like to (please circle one)

REFER ONLY COMANAGE FOLLOW UP

IS THIS A NEW PATIENT? Y or N? TO SEE AT 1 DAY OR 1 WEEK?

PLEASE SEND THIS FORM VIA FAX TO (865) 588-7673
ATTENTION: REBEKAH OR TO EMAIL
physicianreferrals@ccteyes.com