20/20 Optometry of Silicon Valley

2555 N. 1st Street, San Jose, CA 95131 | Phone: (408) 433-0800 | Fax (408) 577-0849

Patient Consultation Request

Patient Information:

Name: _____ DOB: _____

Phone: _____

Reason for referral: _____

Please attach if available:

- Office notes from your clinic visit
- Any labs or imaging reports regarding consultation

Referring Physician Information:

Providers Name: _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

No need to call and schedule an appointment, just fax us this form along with clinical info and we will call and make the appointment with the patient. We will let you know if the patient does not schedule an appointment after several tries. Thank you for letting us care for your patient.