Patient Referral Form

Patient Name: ___________________________________________  DOB: _____________________

Insurance Information: ________________________________________________

(Name of patient’s insurance company & phone number)

Home ph: _________________________________  Work ph: __________________________________

Reason for consultation:   

[ ] Flashes, floaters 379.21  
[ ] Diabetes 250.00

[ ] Glaucoma 365.10  
[ ] Cataract 366.16  
[ ] Red eye 372.00

[ ] Dry eyes 375.15  
[ ] Hi risk medication V58.69  
[ ] Macular degen 362.51

[ ] Other: _____________________________________________________________________

Pertinent history/clinical data: __________________________________________________

________________________________________________________________________________

VA: OD _______20/____  Tonometry: OD ___________  Method:_________________

OS  _______20/____            OS  ___________  Time:___________________

Pertinent Ocular Drawings:  (Corneal/Retinal)

OD

- Please fax or send a copy with the patient.

Referee by: ________________________________

Date:_____________________________________________

E-mail:  __________________________________________

Phone: ___________________________________________

Fax:______________________________________________

Referred by:  ______________________________________

Date:_____________________________________________

E-mail:  __________________________________________

Phone: ___________________________________________

Fax:______________________________________________