retinaOC

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Referral Request

Today's Date:_____

Patient Name: _____ Patient Phone:_____

Referring Doctor: _____

Doctor's Phone: _____ Fax No.: _____

Reason for Consult:

- ❑ Macular Degeneration
- ❑ Diabetic Retinopathy
- ❑ Retinal Detachment
- ❑ Retinal Tear/Hole
- ❑ Other _____
- ❑ Epiretinal Membrane
- ❑ Macular Hole
- ❑ Lens Problem
- ❑ Unexplained Vision Loss
- ❑ Central Serous Retinopathy

Special Services:

- ❑ OCT macula
- ❑ OCT optic nerve
- ❑ Fluorescein
- ❑ ICG Angiography
- ❑ PASCAL laser
- ❑ PDT

Urgency:

❑ Emergency ❑ Next day ❑ Within 1 week ❑ Next availabl e ❑ Call with results

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