

URGENT / SIGHT-THREATENING: Call (941) 909-6006 in addition to faxing this form.**REFERRING PROVIDER**

Practice Provider
Phone Fax Contact
Email

PATIENT INFORMATION

Patient name DOB Phone
Primary insurance Member ID

REFERRAL DETAILS

Urgency: ☐ Same day ☐ 24-48 hours ☐ Within 1 week ☐ Routine Eye: ☐ OD ☐ OS ☐ OU

☐ AMD - wet	☐ AMD - dry	☐ Diabetic retinopathy / DME
☐ Retinal tear	☐ Retinal detachment	☐ Flashes / floaters
☐ Vitreous hemorrhage	☐ Epiretinal membrane	☐ Macular hole
☐ Retinal vein occlusion	☐ Retinal artery occlusion	☐ Central serous chorioretinopathy
☐ Uveitis	☐ Choroidal lesion	☐ Ocular trauma
☐ Decreased vision	☐ Post-op concern	☐ Other Specify:

CLINICAL NOTES / RELEVANT HISTORY**RECORDS / IMAGING INCLUDED**

☐ Office notes ☐ OCT ☐ Fundus photos ☐ Angiography ☐ Insurance card ☐ Other

Scheduling / clinical instructions

SEND COMPLETED REFERRAL**Fax: 351-440-3917****Phone: (941) 909-6006**lakewoodranchretina.com
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