REFERRAL REQUEST FORM

DATE OF SERVICE_______________________________

PRIMARY CARE PHYSICIAN__________________________________

PHONE____

FAX____

PATIENT____

DOB____

REASON FOR REFERRAL: GLAUCOMA ________________

☐ 3 VISITS ☐ 2 VISITS ☐ 1 VISIT

Dear Doctor:

The above named patient presented today at our office with an eye condition that require evaluation(s).

For the well being of the patient, and in an effort to minimize patient expenses with their insurance coverage, we appreciate if you can **FAX** a referral to our office.

I would like to thank you in advance for your help. Please feel free to call our office with any questions.

Optometrist_______________________________________
Our Fax _________________Our Phone_________________
Our Insurance Prov #_________________
Our NPI#__________________________

PCP Doctor's Name__________________________________
PCP Provider #______________________________________
PCP NPI #____
Referral #____
Visits Approved_____________________________________