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New Patient Referral Form

Office Contact Person: _____ Date: _____

Referring Doctor: _____ Office Location: _____

- | | | |
|--|---|---|
| ☐ Anterior Ophthalmology – Any Doctor | ☐ Retinal Ophthalmology – Any Doctor | ☐ Uveitis Consult |
| ☐ Thomas Brummer, MD | ☐ Karishma Habbu, MD | ☐ Karishma Habbu, MD |
| ☐ Michael Morris, MD | ☐ Dwight Silvera, MD | ☐ Shivani Reddy, MD |
| ☐ Monica Kalia, OD | ☐ Nathan Pelsor, OD | ☐ Drew Sommerville, MD |
| | ☐ Andrew Strand, DO | |

Patient Name: _____ Date of Birth: _____

Address: _____ City, St, Zip: _____

Phone Number: _____

Does the patient reside in a nursing home or a similar facility? ☐ Yes ☐ No

Are you a participating provider for this patient's medical insurance plan? ☐ Yes ☐ No

Do you wish to participate in the post-op co-management for this patient? ☐ Yes ☐ No

Consult Request: _____ Diagnosis: _____

☐ Cataract ☐ YAG Cap ☐ Cornea ☐ Retina ☐ LASIK Request LASIK Info? ☐ Call patient / ☐ Send Literature

☐ Other: _____

☐ Coordination of Glaucoma Care:

☐ One-time consult ☐ Transfer glaucoma management ☐ Comanage

☐ I will follow for routine care only ☐ Other: _____

☐ Coordination of Uveitis Care:

☐ Please send previous labs and treatment plan as well as exam notes from the exam where uveitis was first presented

****Please attach all available visual field and imaging records regarding prior glaucoma treatment to aid in our treatment planning****

Current Glasses Rx:	Manifest:	BCVA	Glare:
OD: _____	OD: _____	OD: _____	OD: _____
OS: _____	OS: _____	OS: _____	OS: _____
Add: _____			

Does the patient wear contact lenses? ☐ Yes ☐ No ☐ Past ☐ Present

Contact Lens Rx:	BCVA:	Monovision? ☐
OD: _____	OD: _____	OD: Distance / Near
OS: _____	OS: _____	Multifocal? ☐

****The last examination must be attached with the referral form for the referral to be reviewed****

Additional Information: _____

For In Office Use Only

Patient contacted by: _____ Appointment Date/Time: _____ Office Location: _____