

ILLINOIS RETINA ASSOCIATES THE RETINA CENTER



REFERRAL FORM

I am sending this patient to you for assistance with his/her care. Please evaluate this patient's problem(s) or condition(s).

DATE	PATIENT NAME	PATIENT D.O.B.	PATIENT PHONE
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20-0-02	Eye	Without Correction	With Correction		DILATE BOTH EYES	SPECIAL DILATING INSTRUCTIONS
	RE			YES		
	LE			NO		

Ocular History: (Diagnostic justification for each eye if tests ordered)	
RE	
LE	

PROCEDURE	PLEASE INDICATE AREAS OF SPECIAL INTEREST ON DRAWING
<input type="checkbox"/> Retinal Examination with Diagnostic Tests and Treatment, if indicated	
<input type="checkbox"/> Retinal Examination Only	
<input type="checkbox"/> Fluorescein Angiogram & Color Photographs Transit RE / LE	
<input type="checkbox"/> Color Photographs	
<input type="checkbox"/> OCT	
<input type="checkbox"/> Ultrasound <input type="checkbox"/> Other	

PRINTED REFERRAL NAME _____

REFERRAL SIGNATURE _____

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