Pediatric Ophthalmology & Adult Strabismus Referral Form

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Please fax this form along with the Physician notes, demographics, and copy of insurance card(s) so we can contact the patient to schedule an appointment.****PLEASE NOTE**** We do not see patients 5yo and up for routine eye exams.

Patient Name: _____ DOB: _____ Phone #: _____

Insurance Name: _____ Subscriber ID #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Date Patient was examined: _____

Reason for Consult Request/Referral:

- ▢ Strabismus Evaluation
- ▢ Clogged Tear Duct:
- ▢ Double Vision
- ▢ Amblyopia
- ▢ Trauma
- ▢ Nystagmus
- ▢ Hemangioma
- ▢ Anisocoria
- ▢ Abnormal Red Reflex
- ▢ Ptosis
- ▢ Chalazion
- ▢ Other:_____

I feel the appropriate time period for this patient to be seen is:

STAT*	**URGENT**	**NEXT AVAILABLE**
1-2 Weeks	**1-3 Months**	**4-6 Months**

Referring Doctor Name: _____

Referring Doctor's Phone Number: _____

Referring Doctor's Fax Number: _____

Pediatrician Name: _____

Pediatrician's Phone Number: _____

Pediatrician's Fax Number: _____

Signed: _____ Date:_____
Referring Doctor Signature