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|--|---|
| C. Armitage Harper, III, M.D. <input type="checkbox"/> | Edward H. Wood, M.D. <input type="checkbox"/> |
| Jose Agustin Martinez, M.D. <input type="checkbox"/> | Aaron B. Roller, M.D. <input type="checkbox"/> |
| James W. Dooner, M.D. <input type="checkbox"/> | John Fitzpatrick, M.D. <input type="checkbox"/> |
| Mark Levitan, M.D. <input type="checkbox"/> | Saagar N. Patel, M.D. <input type="checkbox"/> |
| Peter A. Nixon, M.D. <input type="checkbox"/> | Rolake Alabi, M.D. <input type="checkbox"/> |
| Robert W. Wong, M.D. <input type="checkbox"/> | Luca Rosignoli, M.D. <input type="checkbox"/> |
| Shelley Day Ghafoori, M.D. <input type="checkbox"/> | Christian Leal, M.D. <input type="checkbox"/> |
| Ryan C. Young, M.D. <input type="checkbox"/> | Laura L. Snyder, MD <input type="checkbox"/> |
| Philip P. Storey, M.D. <input type="checkbox"/> | |

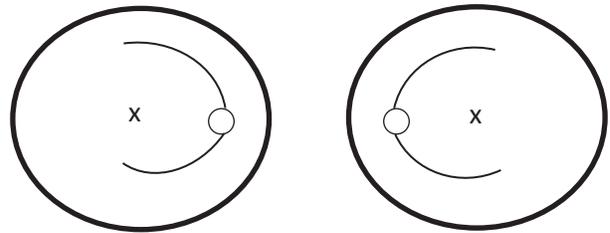
Patient Referral Form

PATIENT NAME: _____ DOB: _____ CELL #: _____

DATE EXAMINED: _____ REFERRING PHYSICIAN: _____

For any referral related questions or concerns, please contact referrals@austinretina.com or call our office.

BRIEFLY STATE THE REASON FOR THE REFERRAL	PLEASE DIAGRAM AREAS OF CONCERN
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VA: CC/SC OD: _____ OS: _____ IOP: OD: _____ OS: _____

DIAGNOSIS	<input type="checkbox"/> TESTING ONLY
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- | | | |
|---|----|----|
| <input type="checkbox"/> Wet AMD | RT | LT |
| <input type="checkbox"/> Dry AMD | RT | LT |
| <input type="checkbox"/> RVO/RAO | RT | LT |
| <input type="checkbox"/> Retinal Hole/Tear/
Detachment | RT | LT |
| <input type="checkbox"/> Epiretinal Membrane | RT | LT |
| <input type="checkbox"/> Diabetic Retinopathy | RT | LT |
| <input type="checkbox"/> Vitreous Hemorrhage | RT | LT |
| <input type="checkbox"/> Macular Hole | RT | LT |
| <input type="checkbox"/> PVD | RT | LT |
| <input type="checkbox"/> Other: _____ | RT | LT |

- Please provide ICD-10 Code here:** _____
- Funds Photography
 - Fluorescein Anigiography
 - B-Scan: *This request will require an exam by an ARA physician*
 - A-Scan (38th Street Office Only) *This request will be reviewed by ARA physician to decide if an exam is needed*
 - UBM (38th Street Office Only) *This request will be reviewed by ARA physician to decide if an exam is needed*
 - OCT Macular Scan
 - OCT Optic Nerve Head Scan
 - Research Study Consideration
 - Other: _____
- Please provide an email address to send results to:

REQUESTED APPT. TIMEFRAME	LOCATION	PATIENT INSTRUCTIONS
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- Immediately (please call us directly)
- Within 48 hours
- Within 1 week
- Within 1 month
- When patient prefers
- Other: _____

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Central Austin | <input type="checkbox"/> Waco |
| <input type="checkbox"/> Round Rock | <input type="checkbox"/> San Marcos |
| <input type="checkbox"/> Lakeway | |
| <input type="checkbox"/> Georgetown | |
| <input type="checkbox"/> Bastrop | |
| <input type="checkbox"/> South Austin | |
| <input type="checkbox"/> Marble Falls | |
| <input type="checkbox"/> Killeen | |
| <input type="checkbox"/> Temple | |

Please bring this form, along with:

- Glasses and eye drops
- List of current medications

Your eyes will be dilated so please arrange for transportation. Your first visit will be very thorough so we kindly request that you plan to be at our office for 2-3 hours.

