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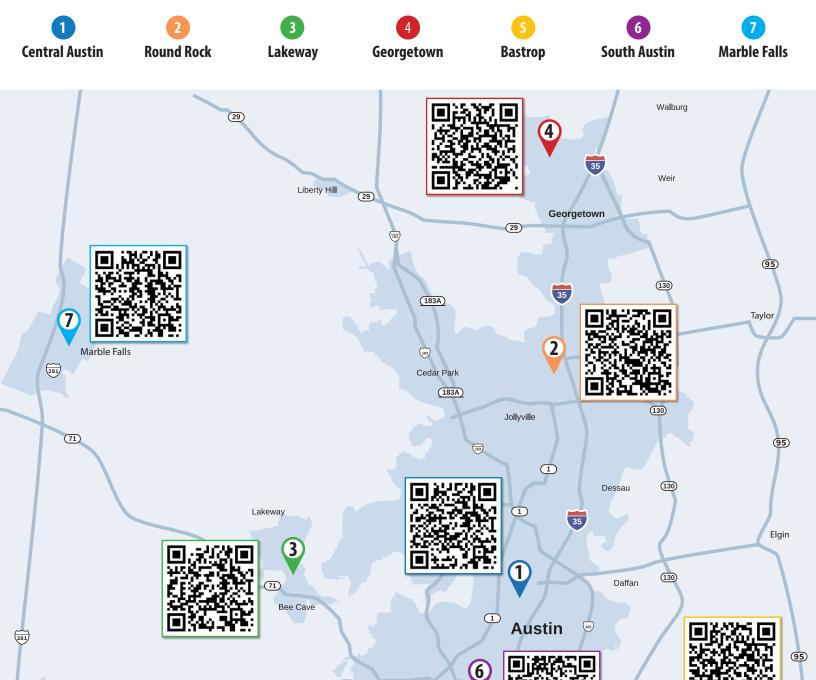
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Philip P. Storey, M.D.
Edward H. Wood, M.D.
Aaron B. Roller, M.D.
John Fitzpatrick, M.D.
Saagar Patel, M.D.
Rolake Alabi, M.D.

Patient Referral Form

TIENT 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					
VA: cc/sc OD:OS		X		X	
DIAGNOSIS	☐ TESTING ONLY				
 □ Dry AMD □ RVO/RAO □ Retinal Hole/Tear/ □ Detachment □ Epiretinal Membrane □ Diabetic Retinopathy □ Vitreous Hemorrhage □ Macular Hole □ PVD 	RT LT		*If testing only please check the box above and include ICD-10 code ICD-10 Code:		
REQUESTED APPT. TIMEFRAME	LOCATI	ON	PAT	IENT INSTRUCTIONS	
 ☐ Immediately (please call us directly) ☐ Within 48 hours ☐ Within 1 week ☐ Within 1 month ☐ When patient prefers ☐ Other: 	□ Main □ South □ Round Roc □ Satellite:	k 	 Glasses List of contract Your eyes where the transport of the transpo	g this form, along with: and eye drops urrent medications vill be dilated so please arrange tation. Your first visit will be gh so we kindly request that	



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