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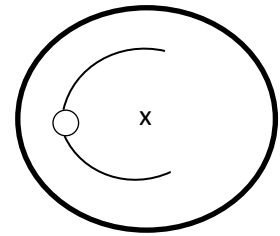
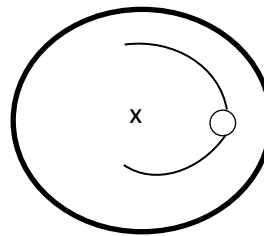
Patient Referral Form

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 |
|---|---------------------------------|
|---|---------------------------------|

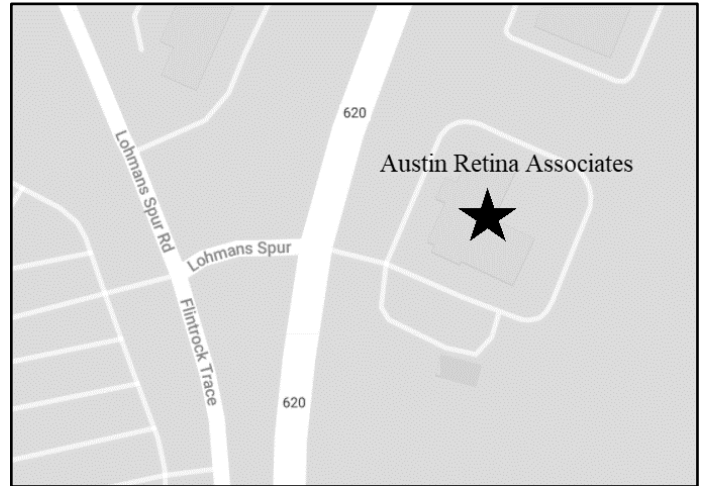
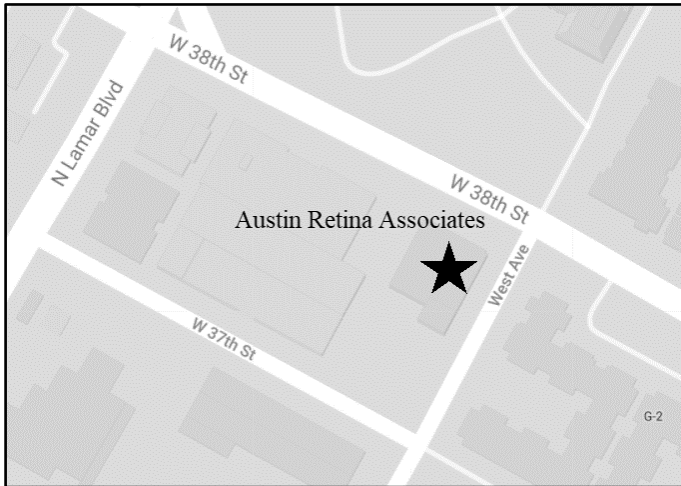


VA: CC/SC OD: _____ OS: _____ IOP: OD: _____ OS: _____

| DIAGNOSIS | <input type="checkbox"/> TESTING ONLY |
|---|--|
| <ul style="list-style-type: none"> <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 | <p><i>*If testing only please check the box above and include ICD-10 code</i></p> <p>ICD-10 Code: _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fundus Photography <input type="checkbox"/> Fluorescein Angiography <input type="checkbox"/> B-Scan <input type="checkbox"/> A-Scan/UBM (38th Street Office Only) <input type="checkbox"/> Automated Visual Fields (38th Street Office Only) <input type="checkbox"/> OCT Macular Scan <input type="checkbox"/> OCT Optic Nerve Head Scan <input type="checkbox"/> Research Study Consideration <input type="checkbox"/> Other: _____ <p>Please provide an email address to send results to:</p> |

| REQUESTED APPT. TIMEFRAME | LOCATION | PATIENT INSTRUCTIONS |
|---|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Immediately (please call us directly) <input type="checkbox"/> Within 48 hours <input type="checkbox"/> Within 1 week <input type="checkbox"/> Within 1 month <input type="checkbox"/> When patient prefers <input type="checkbox"/> Other: _____ | <ul style="list-style-type: none"> <input type="checkbox"/> Main <input type="checkbox"/> South <input type="checkbox"/> Round Rock <input type="checkbox"/> Satellite: _____ | <p>Please bring this form, along with:</p> <ul style="list-style-type: none"> • Glasses and eye drops • List of current medications <p>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.</p> |

Locations

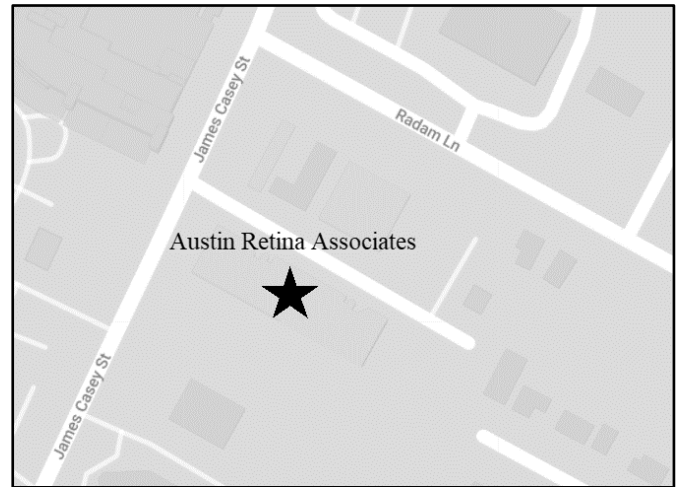
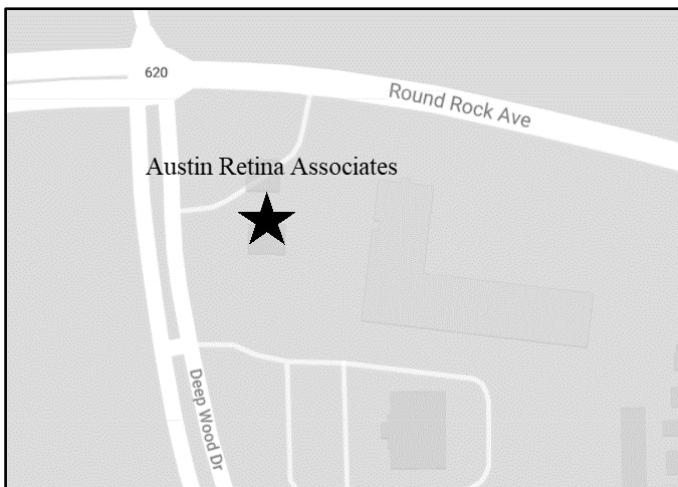


Central Austin

801 West 38th St., #200
Austin, TX 78705
P: (512) 451-0103
F: (512) 451-2741

Lakeway

2501 Ranch Rd. 620 S., #130
Austin, TX 78734
P: (512) 451-0103
F: (512) 2451-2741



Round Rock

1545 Round Rock Ave., #200
Round Rock, TX 78681
P: (512) 610-2820
F: (512) 248-2144

South Austin

4207 James Casey St., #301
Austin, TX 78745
P: (512) 610-2830
F: (512) 383-8335