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Patient Referral Form

PATIENT NAME:	DOB: _						
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							
BRIEFEL STATE THE REASON FOR T	HE REFERNAL	PLEA	SE DIAGRAM	TAREAS OF CONCERN			
		X		x x			
VA: _{CC/SC} OD:OS	8:	IOP: OI	D:	OS:			
DIAGNOSIS			□ TES	STING ONLY			
 □ Wet AMD □ Dry AMD □ RVO/RAO □ Retinal Hole/Tear/ □ Detachment □ Epiretinal Membrane □ Diabetic Retinopathy □ Vitreous Hemorrhage □ Macular Hole □ PVD □ Other: _ R 	T LT	ICD-10 Code Funds Fluore B-Scar A-Scar UBM (OCT M COT CO Resean Other:	CD-10 Code: Funds Photography Fluorescein Anigiography A-Scan A-Scan (38th Street Office Only) UBM (38th Street Office Only) OCT Macular Scan OCT Optic Nerve Head Scan Research Study Consideration Other: Please provide an email address to send results to:				
REQUESTED APPT. TIMEFRAME	LOCATI	ON	PATI	ENT INSTRUCTIONS			
 ☐ Immediately (please call us directly) ☐ Within 48 hours ☐ Within 1 week ☐ Within 1 month ☐ When patient prefers ☐ Other: 	☐ Central Austin☐ South Austin☐ Round Rock☐ Lakeway☐ Bastrop☐ Marble Falls☐ Georgetown☐ San Marcos		 Glasses List of cu Your eyes wifor transportation very thoroug 	this form, along with: and eye drops arrent medications ill be dilated so please arrange ation. Your first visit will be h so we kindly request that be at our office for 2-3 hours.			

