



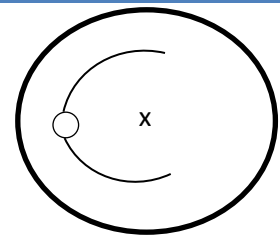
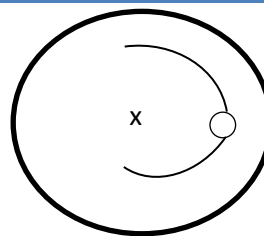
- C. Armitage Harper, III, M.D.
- Jose Agustin Martinez, M.D.
- James W. Dooner, M.D.
- Mark Levitan, M.D.
- Peter A. Nixon, M.D.
- Robert W. Wong, M.D.
- Shelley Day Ghafoori, M.D.
- Ryan C. Young, M.D.
- Philip P. Storey, M.D.

Patient Referral Form

PATIENT NAME: _____ DOB: _____ CELL #: _____

DATE EXAMINED: _____ REFERRING PHYSICIAN: _____

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																														
<table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Wet AMD</td> <td style="text-align: center;">RT</td> <td style="text-align: center;">LT</td> </tr> <tr> <td><input type="checkbox"/> Dry AMD</td> <td style="text-align: center;">RT</td> <td style="text-align: center;">LT</td> </tr> <tr> <td><input type="checkbox"/> RVO/RAO</td> <td style="text-align: center;">RT</td> <td style="text-align: center;">LT</td> </tr> <tr> <td><input type="checkbox"/> Retinal Hole/Tear/ Detachment</td> <td style="text-align: center;">RT</td> <td style="text-align: center;">LT</td> </tr> <tr> <td><input type="checkbox"/> Epiretinal Membrane</td> <td style="text-align: center;">RT</td> <td style="text-align: center;">LT</td> </tr> <tr> <td><input type="checkbox"/> Diabetic Retinopathy</td> <td style="text-align: center;">RT</td> <td style="text-align: center;">LT</td> </tr> <tr> <td><input type="checkbox"/> Vitreous Hemorrhage</td> <td style="text-align: center;">RT</td> <td style="text-align: center;">LT</td> </tr> <tr> <td><input type="checkbox"/> Macular Hole</td> <td style="text-align: center;">RT</td> <td style="text-align: center;">LT</td> </tr> <tr> <td><input type="checkbox"/> PVD</td> <td style="text-align: center;">RT</td> <td style="text-align: center;">LT</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td style="text-align: center;">RT</td> <td style="text-align: center;">LT</td> </tr> </table>	<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> <p>_____</p>
<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																													
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<input type="checkbox"/> Macular Hole	RT	LT																													
<input type="checkbox"/> PVD	RT	LT																													
<input type="checkbox"/> Other: _____	RT	LT																													

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

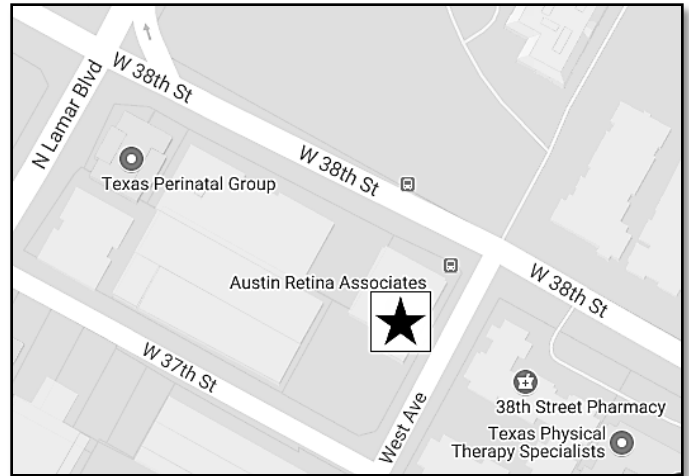
Central Austin

801 West 38th St., #200

Austin, TX 78705

P: (512) 451-0103

F: (512) 451-2741



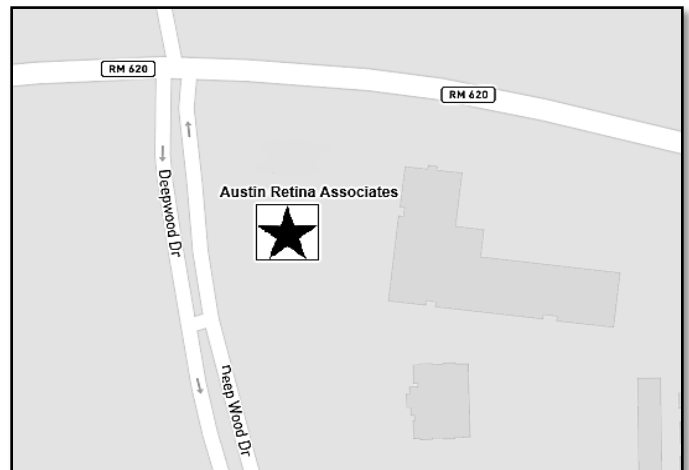
Round Rock

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

