REFERRAL FORM TO RETINA CARE SPECIALISTS

www.retinacarespecialists.com

REFERRING TO:

- ☐ Adrian M. Laviña, MD
- ☐ Paul M. Gallogly, MD
- ☐ Philip W. Laird, MD
- ☐ David A. Levine, MD
- ☐ Fred Y. Chien, MD
- ☐ Anita Barikian, MD

LOCATION PREFERENCE: ☐ PGA ☐ Stuart ☐ PSL ☐ WPB ☐ Boynton

REFERRING DR: _____ **DATE:** _____

PATIENT NAME: _____ **D.O.B.:** _____

PATIENT PHONE: _____ **INS.TYPE:** _____

DATE OF SCHEDULED APPT (if known): _____

VISUAL ACUITY: OD _____ / _____ OS _____ / _____

PRIMARY EYE OF INTEREST: OD / OS

REASON FOR REFERRAL (rule out):

- ☐ Wet / Dry Macular Degeneration / Macular hemorrhage _____
- ☐ Diabetic Retinopathy / Vitreous hemorrhage _____
- ☐ Floaters / Photopsia / PVD _____
- ☐ Retinal Detachment - macula on / off _____
- ☐ Vein Occlusion / Arterial Occlusion _____
- ☐ Macular pucker / Macular hole _____
- ☐ Cystoid macular edema (CME) _____
- ☐ Chronic / Acute Endophthalmitis _____
- ☐ Dislocated IOL / Retained lens fragments _____
- ☐ Choroidal nevus _____
- ☐ Unexplained decrease in vision ☐ Other (please specify) _____

Ocular history/surgery: _____

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