Four Corners Eye Clinic
SPECIALIZING IN MEDICAL AND SURGICAL EYE CARE

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Patient Referral Form

Today's Date: _____

Patient Information:

Name: _____ DOB: _____

Phone #: _____ Medical Insurance: _____

Please FAX a copy of the patient's Medical Insurance Card, pertinent exam findings and last chart note to our office at 970-259-2837. We will contact the patient and schedule an appointment upon receipt of records.

Preferred Dr. or 1st available _____

Referral For: ____RIGHT EYE _____LEFT EYE _____BOTH EYES

BCVA: OD_____ OS_____

Most Recent MRx: OD_____ OS_____

Diagnosis:

____Glaucoma IOP: OD _____ OS _____
____Diabetic Retinopathy
____Macular Degeneration
____Macular Hole
____Retina Evaluation
____Cataracts
____PCO (Yag Laser Referal)
____Eyelid Disorder (Ectropion, Entropion, ptosis, bleph, lesions, etc.)
____Refractive / LASIK Consult
____Dry Eye Disease
____Other / Additional Notes: _____
_____
_____
_____

How Soon Does the Patient Need to Be Seen:

[ ] Emergency (Please call our office at (970) 259-2202
[ ] Urgent (1 to 2 days) [ ] Timely (1 to 2 weeks)

Referring Doctor: _____Office phone #_____