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:

___Macular Degeneration
___Glaucoma IOP: OD_______ OS________
___Diabetic Retinopathy
___Retina Evaluation
___Cataracts
___PCO (Yag Laser referral)
___Dry Eye Disease
___Other: ____

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 #___________________

Thank you for your kind referral.

FOR FCEC USE ONLY

___ Appt scheduled Date___________ Time____________ Physician_____________________

___ Records received

___ Appt. not scheduled: Unable to contact the patient after 3 attempts:
1st attempt date:___________ 2nd attempt date ___________ 3rd attempt date _____________