Four Corners Eye Clinic

SPECIALIZING IN MEDICAL AND SURGICAL EYE CARE

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Retina Referral Form

Patient's Name: ___________________________ DOB:_______________ Phone #:________________________

Referring Physician:_________________________ Last exam date: __________________________

Reason for Evaluation: ☐ OD ☐ OS ☐ OU

BCVA: OD:____________

OS:____________

☐ Macular Degeneration

☐ Retinal Detachment / Tear

☐ Macular Hole

☐ Diabetic Retinopathy

☐ Other: ____

☐ Urgent 1-2 days (please call our office 970-259-2202) ☐ Next Available 1-2 weeks

Other Relevant findings / concerns: ____

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Thank you for your referral and trusting us with your patient's care.