



Ophthalmology Practice Information

Practice Name _____

Address _____

Phone _____ Email _____ Fax _____

Standard Ophthalmology Referral Intake Form

Name and contact info of referring practice:

Practice Name _____

Referring practitioner _____ Date of referral _____

Practice address _____

Phone number _____ Email _____

Name/demographics/contact info of patient:

Name _____ Age _____

Address _____

Phone _____ Email _____

Notes regarding reason for referral:

Diagnosis _____

Relevant history _____

Patient management options:

Expectations from this referral:

☐

Evaluation only

☐

Evaluation and treatment

☐

Please refer the patient back to the referring practice after evaluation/treatment

☐

There is no need to refer the patient back to the referring practice

Low Vision services (The standard of care is to refer visually impaired individuals for low vision care)

If this patient is visually impaired, should we:

☐

Refer the patient back to the referring doctor to provide or refer for low vision care, or

☐

Our office will refer patient directly to a low vision provider

Comments/Notes, etc.