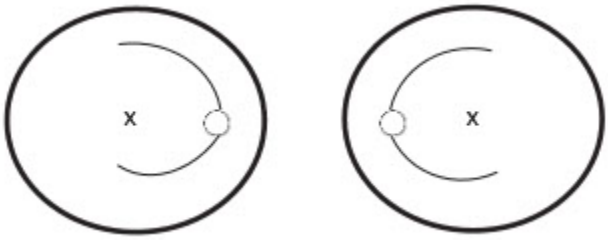
Patient Referral Form

PATIENT NAME_____ DOB: _____ PT PHONE #:_____

LAST EXAM DATE: _____REFERRING PROVIDER:_____

BRIEF REASON FOR REFERRAL	PLEASE DIAGRAM AREAS OF CONCERN
_____ _____ _____ VA: CC / SC OD: _____ OS_____	 IOP: OD: _____ OS: _____

DIAGNOSIS

□ Wet AMD	RT	LT
□ Injection Eval		
□ Susvimo Eval *NEW*		
□ Dry AMD	RT	LT
□ Photobiomodulation *NEW*		
□ Injection Eval		
□ RVO/RAO	RT	LT
□ Retinal Hole/Tear/Detachment	RT	LT
□ Epiretinal Membrane	RT	LT
□ Diabetic Retinopathy	RT	LT
□ Vitreous Hemorrhage	RT	LT
□ Macular Hole	RT	LT
□ Floaters/PVD	RT	LT
□ Exam (New Onset)		
□ Exam (Chronic)		
□ Floaterectomy Eval (PPV)		
□ MacTel	RT	LT
□ ENCELTO Implant Eval *NEW*		
□ Other:_____	RT	LT

REQUESTED APPOINTMENT TIMEFRAME

- ☐ Immediately (please call us directly)
- ☐ Within 48 hours (please call us directly)
- ☐ Within 1 week
- ☐ Within 1 month
- ☐ Next Available / When patient prefers
- ☐ Other: _____

PATIENT INSTRUCTIONS

Patient should bring the following to appmt:

- Glasses, eye drops, and list of current medications
- ID and medical insurance card(s)

Eyes will be dilated so please arrange for transportation. Pt's first visit will be very thorough so we kindly request that they plan to be at our office for 1-2 hours.

PLEASE FAX COMPLETED FORM & PATIENT INSURANCE CARD TO 605-318-5101

Thank you for entrusting us with your patient's care.

www.vravision.com | 5418 E Arrowhead Pkwy, Sioux Falls, SD 57110 | Phone: (605) 705-3322