RETINA
SPECIALISTS OF TAMPA

PATIENT REFERRAL FORM

TO: APPOINTMENT DESK
FAX: 813-973-3888

Please include patient notes with fax request. We will call your office once the appointment is made.

From Dr. _____

Phone: _____

Date: _____

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

Address: _____ City:_____ State:____ Zip:_____

Primary Phone: _____

Insurance Carrier: _____ PPO ___ EPO ___ Medical Supplement: ____

Other: _____

Subscriber #: _____ Group #: _____

(Please obtain pre authorization if needed) PRE AUTH #: _____

Best Time to Call: _____ Diagnosis: _____ OD ◯ OS ◯ OU ◯

PURPOSE OF APPOINTMENT:

☐ Retina Consultation

☐ Uveitis

☐ Retinal Tear | Hemorrhage | Detachment

☐ Diabetic Retinal Evaluation

☐ Macular Degeneration Evaluation

Special Instructions

_____

_____

_____

_____