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:

Special Instructions

____ Retina Consultation _____

____ Uveitis _____

____ Retinal Tear | Hemorrhage | Detachment _____

____ Diabetic Retinal Evaluation _____

____ Macular Degeneration Evaluation