NEW ENGLAND RETINA CARE

# Patient Referral Form

- Please send this form via fax to **(617) 505 – 4051** or via email to **info@neretinacare.com**
- For emergencies, Call our office at **(617) 634 – 0001**
- Attach a copy of your office visit note to this form
- Please provide us with your office contact for any further information needed and to send consultation results

## REQUESTED APPOINTMENT TIME FRAME

☐ Immediately (please call) ☐ Within One Week ☐ Within One Month ☐ Other: _____

## PATIENT INFORMATION

| Patient's Name | Date of Birth (MM/DD/YY) | ☐ Male ☐ Female |
|---|---|---|
| Preferred Phone | Alternate Phone (Optional) | Email Address |

## REASON FOR REFERRAL

| | | |
|---|---|---|
| ☐ Wet AMD | ☐ Diabetic Macular Edema | ☐ Epiretinal Membrane |
| ☐ Dry AMD | ☐ Non-proliferative Diabetic Retinopathy | ☐ Macular Hole |
| ☐ Flashes and Floaters | ☐ Proliferative Diabetic Retinopathy | ☐ Dislocated Lens |
| ☐ Retinal Tear/Hole | ☐ Retinal Vein Occlusion (BRVO/CRVO) | ☐ Suspicious Retinal Lesion |
| ☐ Retinal Detachment | ☐ Retinal Artery Occlusion (BRAO/CRAO) | ☐ Other: _____ _____ |

Physician Notes (optional):

## REFERRING PHYSICIAN INFORMATION

| Referring Physician's Name | Referring Physician's Email | |
|---|---|---|
| Contact Name at Office | Phone | Fax |