

PATIENT REFERRAL FORM



**UPLAND
RETINA**

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REFERRING INFO

Urgent (within 24 hours)

☐ Yes ☐ No

Referring Doctor		Date
Phone:	Fax:	Email (optional)

PATIENT INFO

Please kindly remind patients a referral may be necessary from their primary physician depending on their insurance

Patient Name	Phone	Date of Birth
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Reason for Consultation/Treatment:

☐ Right Eye (OD)

☐ Left Eye (OS)

☐ Both Eyes (OU)

- ☐ Macular Degeneration/AMD
- ☐ Macular Hole or Pucker
- ☐ Retinal Vein Occlusion
- ☐ Cystoid Macular Edema

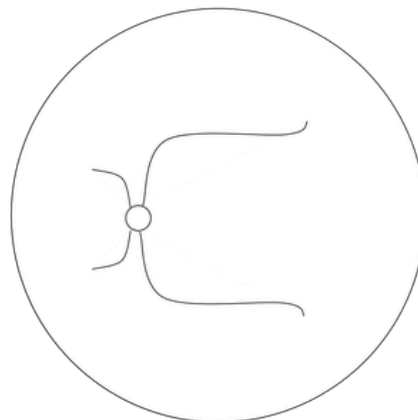
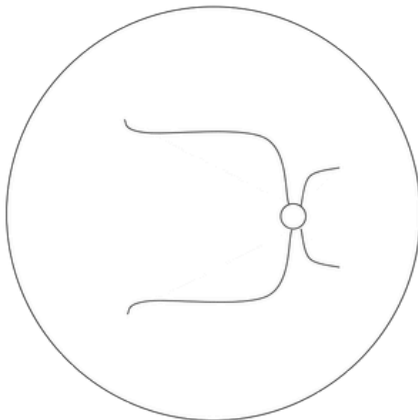
- ☐ Diabetic Retinopathy
- ☐ Retinal Tear/PVD
- ☐ Retinal Detachment
- ☐ Retinal/Vitreous Hemorrhage

- ☐ IOL/Lens Issue
- ☐ Plaquenil Screening Ocular
- ☐ Nevus/Melanoma

OD

Area of concern & additional comments:

OS



Specify if:

☐ Testing only

☐ Ultrasound

☐ OCT

☐ Fluorescein Angiogram (WF)

☐ Fundus Photography (WF)

☐ Notes: _____

PLEASE FAX FORM/RECORDS TO 626-317-8128 OR GIVE TO PATIENT