PHYSICIAN REFERRAL FORM

EYE DOCTORS OF SOUTH FLORIDA

Fax: (844) 811-8816
Phone: (786) 773-2424
9473 W Flagler St, Miami, FL 33174

Please complete the form, attach pertinent records, and fax to our office. We will contact the patient to arrange care.

NOT FOR EMERGENCIES

1 REFERRING CLINICIAN / MEDICO QUE REFIERE

Today's date / Fecha

Referring clinician / Medico que refiere

NPI

Practice / Clinica

Office phone / Telefono

Office fax / Fax

Contact person / Persona de contacto

Secure office email (optional) / Correo seguro (opcional)

2 PATIENT INFORMATION / INFORMACION DEL PACIENTE

Patient full name / Nombre completo

Date of birth / Fecha de nacimiento

Preferred phone / Telefono preferido

Alternate phone / Telefono alternativo

Preferred language / Idioma

Primary insurance / Seguro primario

Member ID / Identificacion

Secondary insurance / Seguro secundario

Member ID / Identificacion

3 REASON FOR REFERRAL / MOTIVO DE REFERIDO

Requested evaluation / Evaluacion solicitada

- ☐ Glaucoma
- ☐ Cataract / Catarata
- ☐ Diabetic eye / Diabetes
- ☐ Pterygium
- ☐ Comprehensive / General
- ☐ Dry eye / Ojo seco
- ☐ Urgent - call office / Urgente - llame
- ☐ Other / Otro

Diagnosis, symptoms, and clinical question / Diagnostico, sintomas y pregunta clinica

Relevant history, medications, allergies, or special considerations / Historia, medicamentos, alergias o consideraciones

4 RECORDS AND AUTHORIZATION / DOCUMENTOS Y AUTORIZACION

- ☐ Office note
- ☐ Medication list
- ☐ OCT / imaging
- ☐ Visual field
- ☐ Photos
- ☐ Other

Referral / authorization number (if required)

Person completing form

FAX COMPLETED FORM AND PERTINENT RECORDS TO (844) 811-8816

For an eye emergency, use the emergency-care guidance on our website. For a life-threatening emergency, call 911.