PATIENT REFERRAL TO INSIGHT EYE ASSOCIATES

Insight EYE ASSOCIATES

Date:_____/_____/_____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Last Four of SSN:_____

Address: _____ Phone: _____

Insurance Name: _____ Patient Insurance/Member ID: _____

Insurance Primary's Name: _____ Primary's DOB: _____ Primary's SSN: _____

REFERRAL OFFICE

Office Name:_____ Physician Name:_____

Office Phone: _____ Office Fax:_____

Office Email: _____ Preferred Form of Communication: _____

REASON FOR REFERRAL

❍ Diabetic Exam ❍ Glaucoma Evaluation ❍ Ocular Injury ❍ Corneal Abrasion ❍ Conjunctivitis

❍ Blurry Vision ❍ General Eye Pain ❍ Plaquenil Screening ❍ Other Ocular Condition (explain) _____

_____

Any Prior Ocular HX/Treatment? (explain)_____

_____

Special Requests/Information (explain) _____

_____

SCHEDULING

Timeframe for our office to see the patient:

❍ Urgent/Emergent/Same Day ❍ Within 1-2 Weeks ❍ Within 1-2 Months ❍ Other (explain) _____

_____

Thank you for allowing us to practice in the care of your patient. We will call your office when we have an appointment confirmed with the patient, and we will send a summary of the evaluation within 1-2 business days after the patient's examination. If you have any special requests or need any information from us, please call or email our office. Dr. Lee and Dr. Pierce are happy to discuss anything over the phone at any time.

Aaron Lee, O.D. & Jordan Pierce, O.D., Therapeutic Optometrists & Glaucoma Specialists
3924 North Tarrant Parkway | Ft Worth, TX 76244 | p 817.514.2114 | f 817.514.2150 | insighteyetx.com