Referral Form

FORT COLLINS
FAMILY EYE CARE

Thank you for choosing Fort Collins Family Eye Care.
We look forward to partnering with you in your patient's care.

Referring Provider Information

Referred by: _____ OD/ MD / DO / PA / NP / OT / PT other_____

Address: _____ City: _____ Zip: _____

Phone: _____ - _____ - _____ Fax: _____ - _____ - _____ Direct Phone: _____ - _____ - _____

Ext _____ PCP: _____ Follow-up Report Desired? Y / N

Patient Information

Last Name: _____ First Name: _____ MI:_____ Gender: M / F

DOB: _____/_____/_____ Phone: _____ - _____ - _____ Interpreter Requested: Y / N

Patient's Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Medical Insurance Carrier:_____ Policy Number:_____ HMO or PPO

Primary Insurance Holder:_____ Primary's DOB:_____ Do they have VSP? Y / N

Employer:_____ Position:_____ Part or Full time

Reason for Referral

Diagnosis/ICD-10: _____

□ Cataract □ Cornea □ Contact Lens Rehabilitation Program □ Culturing □ Dry Eye/Ocular Surface Disease □ Eye Emergency

□ Eyelids &Ocular Skin Care □ Neurolens Evaluation □ Glaucoma □ Glasses □ High Risk Meds □ Neuro Eval □ Pediatric Eval

□ Red Eye □ Retinal Imaging □ Visual Field/VEP/ERG □ Vision Performance Center □ Lesion Removal

Type of Service Requested: □ Consultation □ 2nd Opinion □ Follow Up □ Minor Surgery □ Specify other
_____
_____

Documentation Required (please fax with this form)

- **Most current clinical notes and test results i.e. history, physical, Labs/MRI/CT/X-ray results**
- **Copy of demographic Sheet, insurance card(s) and pre-authorization information, if required**
- **Copies of any OCT/VF/Surgical/Refractive/Cycloplegic information**