



# Referral Form

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  Neuro Lens 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  2<sup>nd</sup> 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

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