



RETINA HEALTH INSTITUTE

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847-488-1030 (Office)

847-488-0677 (Fax)

REFERRAL FORM

Thank you for choosing to refer your patient to us. To start the referral process, please fax this form to **847-488-0677**.

DATE: _____

PATIENT NAME

DOB

PATIENT CONTACT INFORMATION (Include home, work, cell numbers and other contact information)

REFERRING DOCTOR / SPECIALTY / CONTACT INFORMATION

INSURANCE (INCLUDE PATIENT'S INSURANCE CARD (BOTH SIDES) AND HMO AUTHORIZATION (IF REQUIRED))

Scheduled:

Patient to Call:

RHI to Call:

APPOINTMENT

DOCUMENTS ATTACHED

Referral for Retina Consultation

Diagnosis: Macular Degeneration Diabetic Retinopathy Flashes/Floaters Retinal Detachment

Retinal Tear RAO RVO Ocular Tumor Uveitis Unexplained Visual Loss

Other: _____



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