RETINA HEALTH INSTITUTE

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847-488-1030 (Office) 847-488-0677 (Fax)

4855 E State Street, Suite 20, Rockford, IL 61108
815-904-6016 (Office) 815-904-6256 (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))***

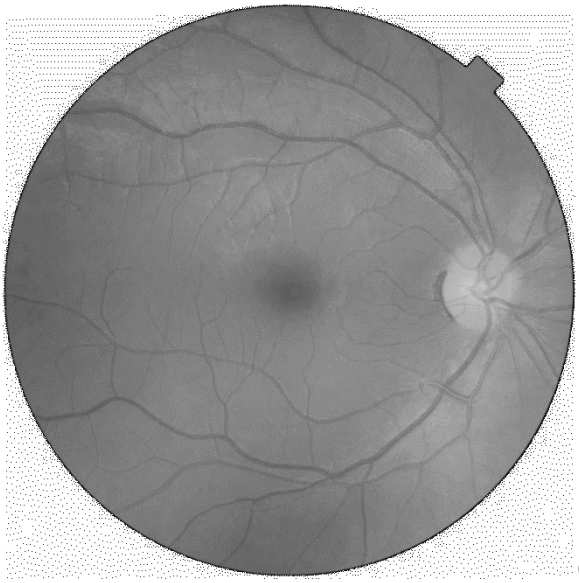
☐ Scheduled: ☐ Patient to Call: ☐ RHI to Call:

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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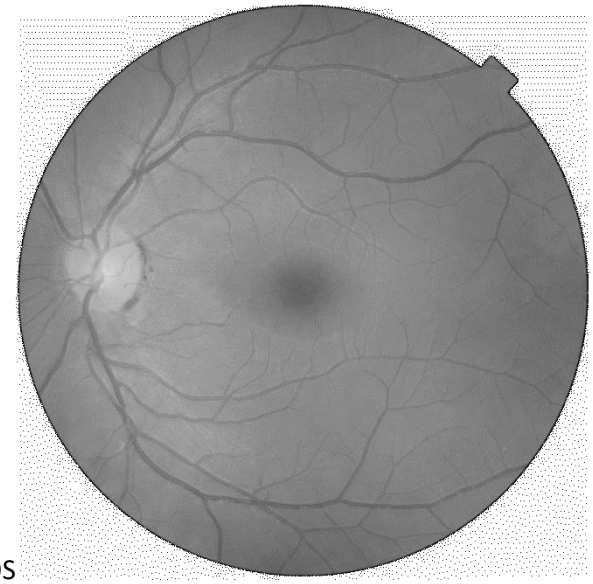

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