

RETINA HEALTH INSTITUTE

2320 N Huntington Dr, Algonquin, IL, 60102

847-488-1030 (Office)

1075 Featherstone Rd, Suite 10, Rockford, IL 61107

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

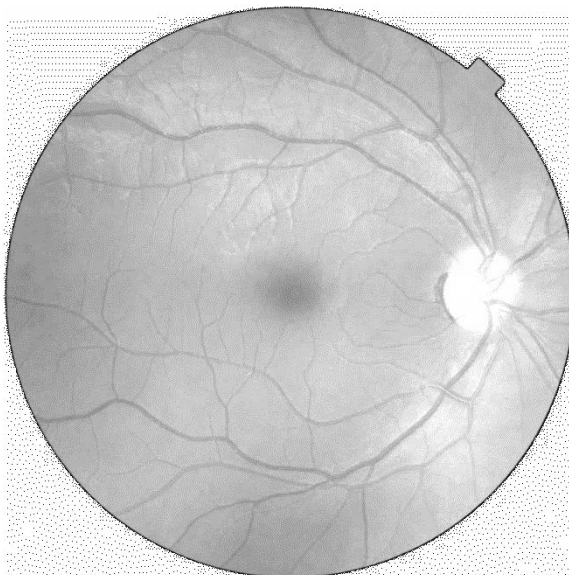
DOCUMENTS ATTACHED

Referral for Retina Consultation

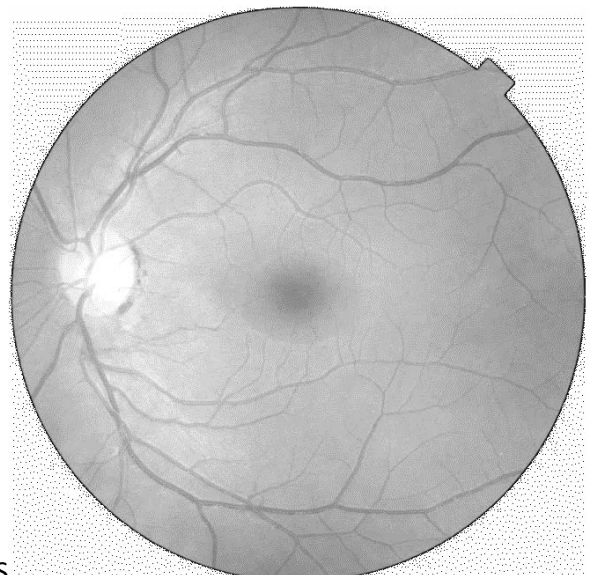
Diagnosis: ☐ Macular Degeneration ☐ Diabetic Retinopathy ☐ Flashes/Floaters ☐ Retinal Detachment

☐ Retinal Tear ☐ RAO ☐ RVO ☐ Ocular Tumor ☐ Uveitis ☐ Unexplained Visual Loss

☐ Other: _____



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