Elman Retina Group, P.A.

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1838 Greene Tree Road
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Patient Referral Form

Patient Name: _____ Exam Date: _____

Referring Physician: _____ Phone: _____

VA: SC / CC OD: _____ OS: _____ IOP: OD: _____ OS: _____

History: _____

_____

_____

Diagnosis: ___ OD ___ OS ___ OU

___ Diabetic Retinopathy
___ Endophthalmitis
___ Epiretinal Membrane
___ Flashes & Floaters / PVD
___ Lattice Degeneration
___ Macular Degeneration
___ Macular Edema
___ Macular Hole
___ Scleritis
___ Retinal Artery Occlusion
___ Retinal Detachment
___ Retinitis Pigmentosa
___ Retinal Tear/Hole
___ Retinal Vein Occlusion
___ Trauma
___ Uveitis
___ Vitreous Hemorrhage
___ Secondary IOL

Other: _____

Have we previously seen this patient? ___ Yes ___ No

Would you prefer a telephone follow up in addition to correspondence regarding this patient? ___ Yes ___ No

For any questions or concerns please feel free to contact our office.
Please fax to 1-443-451-8502. Thank you for your referral!

www.elmanretina.com