ICON EYECARE

Western Slope Retina Referral

FAX TO: 970.256.9149

Is this Urgent? Yes ❑
Call: 970.325.2426

Patient Name: _____ Date of Birth: ___/___/_____ Gender: _____

Cell Phone Number: (___) ___-_____ Home / Work Phone Number: (___) ___-_____

Patient's Preferred Language: _____

Referring Provider/Practice: _____

Phone: (___) ___-_____ Fax: (___) ___-_____

NON-SURGICAL REFERRAL REASON - CHECK ALL THAT APPLY

*Please include **most recent clinic notes** with **relevant testing** as well as a copy of patient's **insurance card***

- ❑ Macular Degeneration
  Wet Dry Indeterminate
- ❑ Diabetic Retinopathy
- ❑ Edema
- ❑ Retinal Tears
- ❑ Floaters and Flashes
- ❑ Lattice
- ❑ Central Serous
- ❑ Vein Occlusion

OTHER INFO OR REFERRAL FOR UNLISTED CONDITION: _____

Pertinent Retina Findings: _____

_____

_____

Duration of New Symptoms: _____

Found on routine eye exam?
YES / NO

BCVA: OD: _____ x _____ 20/_____

OS: _____ x _____ 20/_____

Current IOP: OD: _____ OS: _____

DESIRED TEAM APPROACH FOR RETINA REFERRALS:

- ❑ Referring provider to manager patient when stable
- ❑ ICON doctor will manage referred condition and patient will continue routine care with referring clinician

Referring Provider Signature: _____ Date: _____