



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)
Floaters and Flashes
Diabetic Retinopathy
Lattice
Edema
Central Serous
Retinal Tears
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 manage patient when stable
ICON doctor will manage referred condition and patient will continue routine care with referring clinician

Referring Provider Signature: _____ Date: _____