EYE CARE INSTITUTE

See the best in Sonoma County

REFERRAL FORM

Referring Doctor:_____

Contact number: Phone _____ Fax_____

Patient Name: _____

DOB: _____ Address: _____

Phone number: Cell_____ Home_____

Medical insurance: _____

(please fax a copy of insurance card)

Is this an urgent referral? ☐ Yes ☐ No

Indication for referral:

- ☐ Decreased Vision
- ☐ Eye Pain/ Irritation
- ☐ Chalazion/ Lid Lesion
- ☐ Visual Disturbance
- ☐ Dry Eyes
- ☐ Cataract
- ☐ Glaucoma/ Suspect
- ☐ Diabetes
- ☐ Macular Degeneration
- ☐ Plaquenil Screen
- ☐ Other:

_____

_____

Refer to provider:

- ☐ No Preference
- ☐ Dr. Daniel Rich
- ☐ Dr. Robert Anderson
- ☐ Dr. Bruce Abramson
- ☐ Dr. Kalane Wong
- ☐ Dr. Nina Ni
- ☐ Dr. Lillian Yang
- ☐ Dr. Avni Shah
- ☐ Dr. Arwa Alsamarae

Additional Comments/Notes: _____

_____

Please fax this form to 707-546-4112 Thank you.

INTERNAL USE ONLY:

Completed By:_____

Date Received:_____ Appointment Date:_____