EYE CARE INSTITUTE
A Medical Corporation

# REFERRAL FORM

Referring Doctor:_____

Contact number: Phone _____ Fax_____

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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. Bruce Abramson
- ☐ Dr. Arwa Alsamarae
- ☐ Dr. Venkatesh Brahma
- ☐ Dr. Nina Ni
- ☐ Dr. Daniel Rich
- ☐ Dr. Avni Shah
- ☐ Dr. Lillian Yang

**Additional Comments/Notes:** _____

_____

**Please fax this form to 707-528-4967 or e-mail to referrals@see-eci.com. Thank you.**

**INTERNAL USE ONLY:**

Completed By:_____

Date Received:_____ Appointment Date:_____

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Santa Rosa, CA 95403
referrals@see-eci.com

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www.see-eci.com