Eye Disease
Consultants

Patient Referral Form

PATIENT INFORMATION

- **Name:** _____
- **Date of Birth:** _____ **Phone:** _____
- **Address:** _____
- **City/State/Zip:** _____

REASON FOR REFERRAL

Check all that apply:

☐ Cataract Evaluation ☐ Retinal Evaluation ☐ Other: _____

☐ Glaucoma Evaluation ☐ Anterior Segment

REFER TO PROVIDER (*Please select a physician):*

- ☐ **Alexander R. Gaudio, MD –** ***Diseases of the Retina, Macula & Diabetic Retinopathy***
- ☐ **Paul A. Gaudio, MD –** ***Uveitis, Cornea & Ocular Surface Diseases***
- ☐ **Matthew P. Nicholas, MD, PhD –** ***Medical Retinal Diseases and Comprehensive Ophthalmology***

HISTORY / PERTINENT FINDINGS

_____

_____

REFERRING PROVIDER INFORMATION

- **Referring Provider Name:** _____
- **Signature:** _____ **Date:** _____

**** Uveitis Referrals: Please include recent blood work results with this form. * Insurance: Please ensure the patient obtains any necessary insurance referrals prior to their visit.***

Thank you for your referral.

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