EYE FLORIDA

ADVANCED MEDICAL • SURGICAL • AESTHETIC SERVICES

Ly T. Nguyen, M.D. • Board Certified Ophthalmologist • office: 407-891-2010 • fax: 407-891-8211 • www.eyeflorida.com

PATIENT REFERRAL FORM

PATIENT NAME _____ PATIENT DOB _____

PATIENT INSURANCE_____ PATIENT PHONE # _____

REFERRAL DOCTOR _____ DOCTOR PHONE # _____

Is this an Emergency or Routine?

Reason for referral: (Please fax any pertinent medical records)

❑Blurry or Decreased Vision	❑Surgical Consultation	❑Cataracts
❑Glaucoma	❑Diabetes	❑Macular Degeneration
❑Eye Pain	❑Irritation / Discomfort	❑Dry Eyes / Allergies
❑Visual Disturbance	❑Cosmetic / Aesthetic	❑OTHER

Notes: _____

_____

_____

Thank you for your referral!

To our patients: Please bring this form with you to your appointment. Please notify us if you are unable to keep your appointment.

Main Clinic | 1330 Budinger Ave. Ste 200, St. Cloud, FL 34769 **Satellite Clinic** | 4589 Henry C. Yates Lane, St. Cloud, FL 34769

For Eye Florida Use Only:

____ Appointment Scheduled:
Date: _____Time: _____ AM / PM Location: □ SCMP □ SCEC Physician: _____
____ Appointment NOT Scheduled: Unable to contact the patient after several attempts. 1st Attempt Date: _____ 2nd Attempt Date: _____ 3rd Attempt Date: _____
Date: _____ Fax Confirmation Received: YES Scheduler Initials: _____