POOJA GARG, MD

Vitreo-Retinal Specialist

RETINA

EYE SPECIALISTS

REFERRAL FORM

DIRECTIONS: Please fax to 954-586-4196 or Give to the patient to bring to the appointment

Referring Doctor: ______________________________ Appt Date: __________________

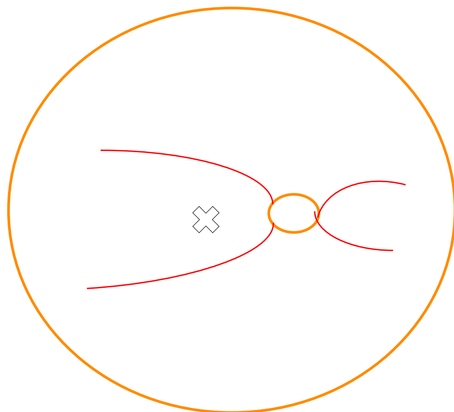
Patient Name: _________________________________ Age ______ DOB: ____________

Patient Number: ______________________________

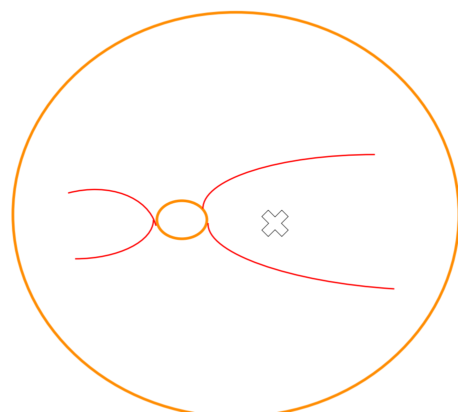
Reason for Consult: **OD** **OS** **OU**

- ☐ Diabetic Retinopathy
- ☐ Macular Degeneration
- ☐ Macular edema / hole / membrane
- ☐ Flashes and Floaters
- ☐ Retinal Tear / Hole / Lattice
- ☐ Retinal Detachment
- ☐ Central / Branch Retinal Vein Occlusion
- ☐ Dislocated Lens
- ☐ Maculopathy
- ☐ Choroidal Nevus / Melanoma / Mass
- ☐ Uveitis
- ☐ Unexplained Visual Loss
- ☐ Other: (please specify)____

OD



OS



Comments: ____

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4515 Wiles Road, Suite 201, Coconut Creek, FL 33073

Telephone: 954-633-8202

Facsimile: 954-586-4196

frontdesk@retinaeyedoc.com

www.RetinaEyeDoc.com