Retina Consultants *of Carolina, P.A.*

PATIENT REFERRAL FORM

DATE _____ PATIENT NAME _____

DOB _____ SSN _____ PRIMARY PHONE _____

ADDRESS _____ MOBILE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY INSUR. _____ EMERG. CONTACT _____

SECONDARY INSUR. _____ EMERG. CONTACT PHONE _____

INSURED PERSON _____ RELATIONSHIP _____

AUTHORIZATION NO. _____ AUTHORIZED BY _____

REFERRING DOCTOR _____ PRACTICE _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ FAX _____

DIAGNOSIS

☐ Macular Degeneration ☐ Diabetic Retinopathy ☐ Flashes/Floaters

☐ Reason for referral _____

URGENT or EMERGENT referrals are required to please call the office @ (864) 233-5722 to schedule

YOUR APPOINTMENT

is on _____ , _____ _____ @ _____ _____ with

☐ First Available; OR specify provider below

☐ Dr. Renfro ☐ Dr. Kaiser ☐ Dr. Bergstrom ☐ Dr. Robinson

☐ Dr. Christensen ☐ Dr. Hall ☐ Dr. Apple ☐ Dr. Ohning

Completed Referral Form can be sent to:
Email: referral@retina-consultants.com
eFax: (864) 233-6027

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