

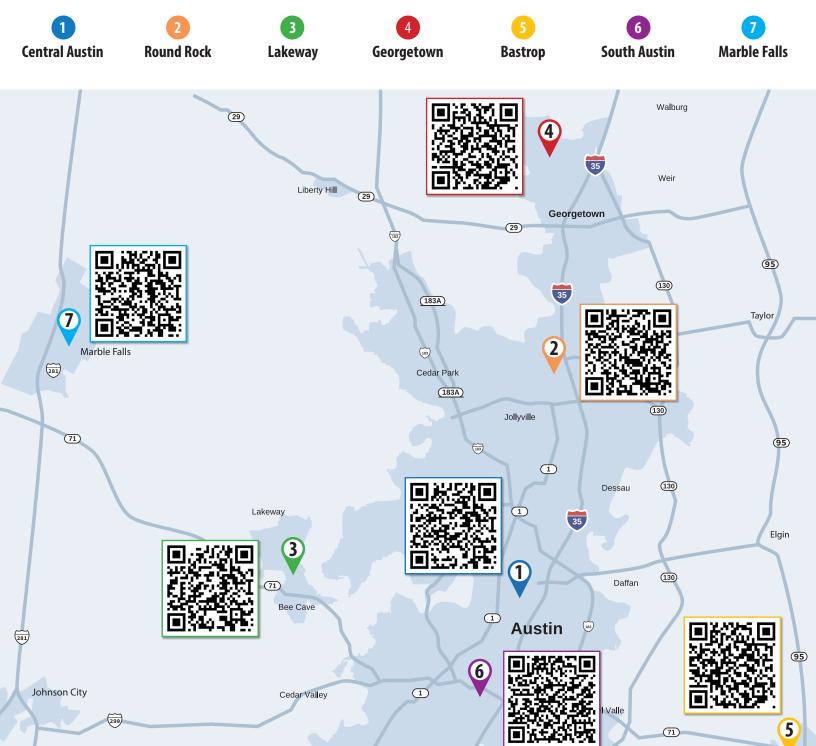
C. Armitage Harper, III, M.D. □
Jose Agustin Martinez, M.D. □
James W. Dooner, M.D. □
Mark Levitan, M.D. □
Peter A. Nixon, M.D. □
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Shelley Day Ghafoori, M.D. □
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Philip P. Storey, M.D. □
Edward H. Wood, M.D. □
Aaron B. Roller, M.D. □
John Fitznatrick M.D. □

Patient Referral Form

PATIENT NAME:	DOB:		CELL #:		
DATE EXAMINED: REFERRING PHYSICIAN: For any referral related questions or concerns, please contact referrals@austinretina.com or call our office.					
BRIEFLY STATE THE REASON FOR T					
VA: cc/sc OD:OS	S:	IOP: OI		OS:	
DIAGNOSIS			□ TES	STING ONLY	
 □ Dry AMD □ RVO/RAO □ Retinal Hole/Tear/ □ Detachment □ Epiretinal Membrane □ Diabetic Retinopathy □ Vitreous Hemorrhage □ Macular Hole □ PVD 	T LT T LT T LT	ICD-10 Cd	ndus Photograndus Photogran (38) Scan (38) Scan/UBM (38) Tomated Visual (38) Tomated Visual (38) Toptic Nervesearch Study	ingraphy sth Street Office Only) al Fields (38th Street Office Only) can	
REQUESTED APPT. TIMEFRAME	LOCATI	ON	PATI	IENT INSTRUCTIONS	
 ☐ Immediately (please call us directly) ☐ Within 48 hours ☐ Within 1 week ☐ Within 1 month ☐ When patient prefers ☐ Other: 	□ Main □ South □ Round Roc □ Satellite:	k 	 Glasses List of cu Your eyes w for transport very thoroug 	this form, along with: and eye drops urrent medications will be dilated so please arrange ation. Your first visit will be the so we kindly request that	



Austin Retina provides 7 main locations in the Austin area and 7 satellite locations covering all of central Texas





Phone: (512) 451-0103 Toll Free: (800) 252-8259 Fax: (512) 451-2741 www.austinretina.com

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