GOLDEN VIEW
OPHTHALMOLOGY

400 Indiana St Ste 270
Golden, CO 80401
720-608-8009
720-306-7236

PATIENT REFERRAL FORM

Thank you for trusting us with your patient's eye care.
Please fax completed form with relevant records to **(720-306-7236)**.

☐ **URGENT REFERRAL**
Please see patient as soon as possible.

1. PATIENT INFORMATION

Patient Name: _____

DOB: _____ Gender: ☐ M ☐ F

Phone: _____

Alternate Phone: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Insurance: _____

Insurance ID: _____

2. REFERRING PROVIDER INFORMATION

Referring Provider: _____

Practice Name: _____

Phone: _____

Fax: _____

Email: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

3. REASON FOR REFERRAL *(Please check all that apply)*

- ☐ Cataract Evaluation
- ☐ Cataract Surgery
- ☐ Glaucoma Evaluation
- ☐ Glaucoma Management / Second Opinion
- ☐ Diabetic Eye Exam / Retinopathy
- ☐ Macular Degeneration
- ☐ Retinal Evaluation
- ☐ Retinal Detachment
- ☐ Macular Hole / Pucker
- ☐ Uveitis / Inflammation
- ☐ Corneal Disease
- ☐ Dry Eye / Ocular Surface
- ☐ Oculoplastics
- ☐ Refractive Surgery Evaluation
- ☐ Other: _____

Clinical Information / Reason for Referral *(please include relevant history, findings, and previous treatments):*

_____

_____

_____

_____

4. RELEVANT CLINICAL INFORMATION

Visual Acuity:
OD: _____ OS: _____

IOP:
OD: _____ OS: _____

Date of Last Exam: _____

Previous Eye Surgeries:
☐ None ☐ Yes If yes, please specify: _____

_____

Relevant Imaging/Testing Attached:
☐ Yes ☐ No
If yes, please list: _____

_____

5. APPOINTMENT REQUEST

Please schedule:

☐ Next available appointment

☐ Within _____ days *(Please specify)*

Preferred times (if any): _____

Additional Comments / Special Instructions:

_____

_____

_____

6. AUTHORIZATION

I certify that the above information is true and accurate to the best of my knowledge and that I am referring this patient for ophthalmologic consultation and treatment.

Referring Provider Signature: _____ **Date:** _____

PLEASE FAX COMPLETED FORM AND ANY RELEVANT RECORDS TO (720-306-7236)

We appreciate your referral and look forward to partnering in your patient's eye care.