

# EYE STUDIO REFERRAL FORM



## REFERRING PROVIDER INFORMATION

Provider Name: \_\_\_\_\_  
Clinic Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

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## PATIENT INFORMATION

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Insurance (if applicable): \_\_\_\_\_

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## REASON FOR REFERRAL (check all that apply)

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|--|--|
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Macular Degeneration                          |
| <input type="checkbox"/> Comprehensive Eye Exam  | <input type="checkbox"/> Myopia Control                                |
| <input type="checkbox"/> Cataracts               | <input type="checkbox"/> Plaquenil (hydroxychloroquine) testing        |
| <input type="checkbox"/> Contact Lens Evaluation | <input type="checkbox"/> Urgent Concern (red eye, pain, sudden change) |
| <input type="checkbox"/> Diabetic Eye Exam       | <input type="checkbox"/> Other: _____                                  |
| <input type="checkbox"/> Dry Eye                 |  |
| <input type="checkbox"/> Glaucoma                |  |
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## CLINICAL NOTES / COMMENTS

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## SUBMISSION OPTIONS

 Fax completed form to 832-975-7021

 Submit online: [eyestudiotx.com/refer](http://eyestudiotx.com/refer)

 Call: 832-975-7020

 Heights Eye Studio / EaDo Eye Studio  
[info@eyestudiotx.com](mailto:info@eyestudiotx.com)

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