

REFERRAL FORM

PATIENT INFORMATION

* Full Name (Last, First, MI) : _____
Use legal name as listed on ID

* Diagnosis : _____

Symptoms & Length of Symptoms : _____

Relevant Medical History and Other Notes for CRA : _____

Urgency of Referral : 48 Hours Within 1 Week Patient Preference ***For ocular emergencies or patients that need to be seen same-day, call us ASAP.***

Affected Eye : Right OD Left OS Both

Date of Birth : _____ / _____ / _____ Sex : Male Female

* Phone Number : _____ ***Preferred phone # required to contact patient.***

E-Mail *optional* : _____

REFERRING PROVIDER INFORMATION

* Provider Name : _____ Designation : _____

Practice Name : _____

Practice City : _____ State : _____

Phone : _____ Fax : _____

APPOINTMENT PREFERENCES

Requested CRA Provider : _____

Perferred Location : Central Park Denver, CO Cherry Creek Denver, CO Lafayette, CO

Patient Preference First Available Lakewood, CO Littleton, CO Parker, CO

* IMPORTANT: Fax below files to (303) 261-1601

- Patient Demographics Insurance Cards Recent Exam Notes Imaging