SWAGEL WOOTTON
EYE INSTITUTE

Patient Referral Form
Fax to: 480-653-8776

Is this URGENT? Yes ☐
Phone: 480-653-8776
Date: _____/_____/20___

PATIENT INFORMATION

Name: ______________________________ Date of Birth: ____/_____/__________

Address: ____

Cell Phone: (______) ______ - ________ Home/Work Phone: (______) ______ - ________

Email: ____

Patient's Medical Insurance: __________________ Do you accept Pt.'s Medical Ins.? Y / N

REFERRING PROVIDER

Name: __________________________ Practice/Location: __________________________

Phone: (______) ______ - ________ Fax: (______) ______ - ________

Email: ____

REASON FOR REFERRAL

- ☐ Cataract Evaluation ☐ Co-manage?
- ☐ LASIK/PRK Evaluation ☐ Co-manage?
- ☐ ICL Evaluation
- ☐ CLE Evaluation
- ☐ Corneal Cross-linking
- ☐ Medical Glaucoma Evaluation
- ☐ Surgical Glaucoma Evaluation
- ☐ Cornea Evaluation
- ☐ Pterygium
- ☐ Uveitis Evaluation
- ☐ Macular Evaluation
- ☐ Yag Evaluation
- ☐ Dry Eye Evaluation
- ☐ Other: __________________________

Chief complaint/concern: ____

____

____

____

Last exam notes enclosed? Y / N

Provider Preference:

- ☐ Dr. Loan Ramsey, MD
- ☐ Dr. JoAnn Reed, MD
- ☐ Dr. Daniel McGehee, OD
- ☐ Dr. Janice Pierce, OD
- ☐ Dr. Renee Hanson, OD
- ☐ Dr. Leah Janousek, OD

Which office would the patient like to be seen at?

- ☐ Mesa
- ☐ Chandler

Referring Provider's Signature: ______________________________ Date: __________