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: _____