SWAGEL WOOTTON
EYE INSTITUTE

Patient Referral Form

Phone/Fax: 480-653-8776

Date: ____/____/20___

PATIENT INFORMATION

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

Cell Phone: (_____)_____ - _____

Email: _____

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

REFERRING PROVIDER

Name: _____ Practice/Location: _____

Phone: (_____)_____ - _____ Fax: (_____)_____ - _____

REASON FOR REFERRAL

- ☐ Cataract Evaluation
- ☐ LASIK/PRK/ICL Evaluation
- ☐ Dry Eye Evaluation
- ☐ Surgical Glaucoma Evaluation
- ☐ Medical Glaucoma Evaluation
- ☐ Macular Evaluation
- ☐ Yag Evaluation
- ☐ Other: _____

For Cataract, LASIK, PRK, ICL, RLE Evaluations: Each patient is evaluated by the surgeon and referring optometrist to determine if co-management is appropriate. If so, the patient may choose to receive post-operative care from the referring optometrist, with the surgeon available as needed.

If your patient requests co-management, please indicate whether you would like to co-manage their post-operative care: ☐ Yes ☐ No

Chief complaint/concern: _____

_____

_____

Last exam notes enclosed? Y / N

Provider Preference:

- ☐ Dr. Loan Ramsey, MD
- ☐ Dr. Joshua Brozek, MD
- ☐ Dr. Janice Pierce, OD
- ☐ Dr. Renee Hanson, OD
- ☐ Dr. Kathleen Vize, OD

Referring Provider's Signature: _____ Date: _____