Is this URGENT? Yes ☐
Phone: (303) 861-2020

CLEAR VISION ASSOCIATES PC

Date: ___/___/___

Patient Referral Form
Fax to: (720) 729-8262

PATIENT INFORMATION

Name: _____ Date of Birth: ___/___/___

Address: _____

Cell Phone Number: ( ) - _____ Home/Work Phone Number: ( ) - _____

Patient's Insurance: _____

Insurance Name Member ID and Group number

REFERRING PROVIDER

Name: _____ Practice: _____

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

Email: _____

REASON FOR REFERRAL (Circle)

- ☐ Pediatric Eye Exam
- ☐ Diabetic Eye Exam
- ☐ Cataract Evaluation
- ☐ Macular Degen Evaluation
- ☐ Glaucoma Evaluation
- ☐ Plaquenil Eye Evaluation (VF, OCT)
- ☐ Dry Eye Evaluation
- ☐ Blurred Vision
- ☐ Red Eye/Eye Infection

Chief complaint/concern: _____

Notes: _____

_____

_____

Referring Provider's Signature: _____ **Date:** _____