

Referral Date: _____

PATIENT REFERRAL FORM

3855 Broad Street, Ste. B
San Luis Obispo, CA 93401
☎ 805.545.8100 ☎ 805.545.8902

816 E. Enos Drive, Ste. A
Santa Maria, CA 93454
☎ 805.346.1717 ☎ 805.346.1525

931 Oak Park Blvd., Ste. 201
Pismo Beach, CA 93449
☎ 805.473.6640 ☎ 805.473.5873

220 Oak Hill Road
Paso Robles, CA 93446
☎ 805.227.1477 ☎ 805.227.1479

1111 E. Ocean Avenue, Ste. 7
Lompoc, CA 93436
☎ 805.735.3468 ☎ 805.735.6461

Referral Coordinator Direct Phone: 805-503-1060 Direct Fax: 805-503-1059 Direct Email: referrals@paceyemd.com

Patient: _____ **Patient Ph. #:** _____

Insurance _____ **Date of Birth** _____

I would like to refer this patient for:

- | | | |
|--|---|--|
| <input type="checkbox"/> Cataract Evaluation | <input type="checkbox"/> Glaucoma Evaluation | <input type="checkbox"/> Consult and Treat |
| <input type="checkbox"/> Corneal Evaluation | <input type="checkbox"/> Eye Lid Evaluation | <input type="checkbox"/> Consult Only |
| <input type="checkbox"/> Refractive Evaluation | <input type="checkbox"/> Comprehensive Eye Exam | |
| <input type="checkbox"/> Strabismus | <input type="checkbox"/> Medical Records Attached | <input type="checkbox"/> Other _____ |

I would like to co-manage this patient

Diagnosis: _____

Pertinent Information: _____

Dr. _____ **Dr.** _____
(printed name) signature

Dr. Phone _____ **Dr. Address** _____

- | | | |
|---|---|---|
| <input type="checkbox"/> First Available | <input type="checkbox"/> Christopher S. Hulburd, M.D. | <input type="checkbox"/> J. Brent Oldenburg, M.D. |
| <input type="checkbox"/> Ahmad A. Amir, M.D. | <input type="checkbox"/> William E. McRee, M.D. | <input type="checkbox"/> Mark D. Sherman, M.D. |
| <input type="checkbox"/> Robert W. Higginbotham, M.D. | <input type="checkbox"/> Craig A. Merrill, M.D. | <input type="checkbox"/> Maziar Bidar, M.D. |

Vitreoretinal Evaluation – Jennifer A. Spiegel, MD

Direct Email: Retina@paceyemd.com Direct Fax: 805-503-1059

Diagnosis:

- | | | | | | |
|---------------------------------------|----|----|---|----|----|
| <input type="checkbox"/> Wet AMD | RT | LT | <input type="checkbox"/> Diabetic Macular Degeneration | RT | LT |
| <input type="checkbox"/> Dry AMD | RT | LT | <input type="checkbox"/> Proliferative Diabetic Retinopathy | RT | LT |
| <input type="checkbox"/> BRVO/CRVO | RT | LT | <input type="checkbox"/> Non Proliferative Diabetic Retinopathy | RT | LT |
| <input type="checkbox"/> Retinal Tear | RT | LT | <input type="checkbox"/> Vitreous Hemorrhage | RT | LT |
| <input type="checkbox"/> ERM | RT | LT | <input type="checkbox"/> Macular Hole | RT | LT |

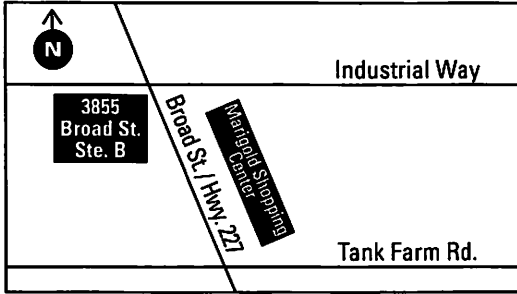
Other (Specify): _____

Requested Appointment Timeframe:

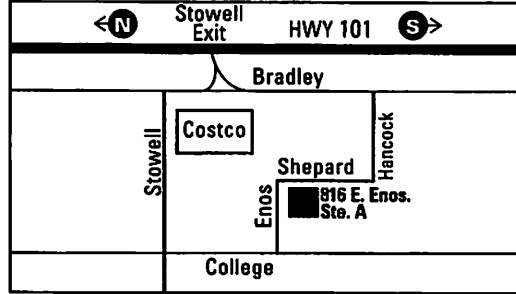
- Immediately
- Within 1 week
- Within 1 month
- When patient prefers

Other: _____

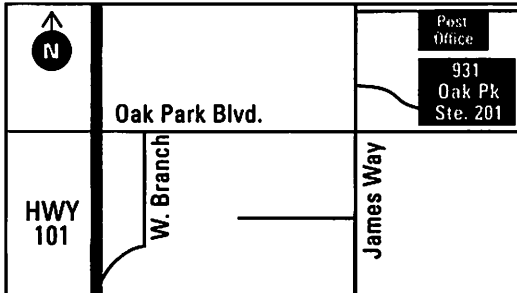
San Luis Obispo Office 805.545.8100



Santa Maria Office 805.346.1717

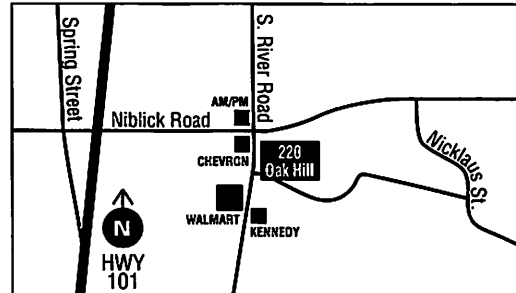


Pismo Beach Office 805.473.6640



enter complex from James Way

Paso Robles Office 805.227.1477



Lompoc Office 805.735.3468

