Physician Referral Form

Please complete this form and fax it to us: 623-999-9013

☐ Urgent
☐ Routine

Patient Name

First Name Last Name

Date of Birth (DOB)

Month Day Year

Insurance

Patient Phone

Area Code Phone Number

Patient Phone (Alternate)

Area Code Phone Number

Referring Physician

First Name Last Name

Referring Phone

Area Code Phone Number

Referring Fax

Email

example@example.com

Reason for Consultation

- ☐ CRVO, BRVO, CRAO, BRAO
- ☐ Diabetic Retinopathy
- ☐ Flashing Lights/Floaters
- ☐ Hereditary Diseases/Genetic Consultation
- ☐ Macular Hole
- ☐ Macular Degeneration
- ☐ Ocular Tumor
- ☐ Retinal Detachment
- ☐ Uvetis

Additional Comments

Preferred Retina Physician

- ☐ Alan J. Gordon, M.D.
- ☐ J. Shepard Bryan, M.D.
- ☐ Stephan A. Souza, M.D
- ☐ Henry Mark Kwong, Jr., M.D.
- ☐ Benjamin Bakal, M.D., P.H.D.
- ☐ Jaime R. Gaitan, M.D.
- ☐ Matthew Welch, M.D.
- ☐ Rima Patel, M.D
- ☐ Setu Patel, MD
- ☐ Kunyong Xu, M.D.
- ☐ 1st Available

Preferred Location

- ☐ Casa Grande
- ☐ Cottonwood

- ☐ Flagstaff
- ☐ Gilbert
- ☐ Goodyear
- ☐ Mesa
- ☐ Payson
- ☐ Peoria
- ☐ Phoenix
- ☐ Prescott
- ☐ Prescott Valley
- ☐ Scottsdale
- ☐ Sedona