NEVADA RETINA ASSOCIATES

PATIENT REFERRAL

Please fax form completed with all relevant chart notes, images, and test results.
Office fax information is listed below.
Thank you for your referral!

STEVE FRIEDLANDER, MD, FACS • ELENA GERAYMOVYCH, MD, FACS, • ROB WELCH, FNP-BC, CRNO

REFERRING PHYSICIAN INFORMATION

NAME: _____ PHONE: _____

FAX: _____ EMAIL _____

☐ HMO
☐ PPO

PATIENT INFORMATION

NAME: _____ DOB: _____

PHONE: _____ EMAIL _____

INSURANCE: _____ ID#: _____

AUTHORIZATION (REQUIRED FOR HMO): _____

☐ Call patient to schedule

☐ Appointment scheduled _____

Diagnosis

☐ Retinal Detachment	RT ☐	LT ☐
☐ Retinal Tear	RT ☐	LT ☐
☐ Wet AMD	RT ☐	LT ☐
☐ Dry AMD	RT ☐	LT ☐
☐ BRVO/CRVO	RT ☐	LT ☐
☐ Epiretinal Membrane	RT ☐	LT ☐
☐ Macular Edema	RT ☐	LT ☐
☐ Diabetic Retinopathy	RT ☐	LT ☐
☐ Vitreous Hemorrhage	RT ☐	LT ☐
☐ Vitreous Floater/PVD	RT ☐	LT ☐
☐ Macular Hole	RT ☐	LT ☐
☐ Nevus/Melanoma/Tumor	RT ☐	LT ☐
☐ Retinal Dystrophy	RT ☐	LT ☐
☐ Uveitis	RT ☐	LT ☐

☐ Other: _____

Requested Appt. Timeframe

☐ Immediately/ASAP
PLEASE CALL OFFICE

☐ Within one week

☐ Within one month

☐ When patient prefers

Preferred Office

☐ **RENO**

☐ **CARSON CITY**

Phone: 775-356-7272

Fax: 775-356-2922

OFFICE INFORMATION ON BACK

Fax this form along with the last chart notes and patient demographics. Upon receipt, we will contact the patient within one to two business days to schedule the requested appointment.

Reno

610 Sierra Rose Drive • Reno, NV 89511
775-356-7272

CARSON CITY

1525 Vista Lane, Suite 110 • Carson City, NV 89703
775-283-4000