Retina Referral Form

VANCE THOMPSON VISION

Patient's Name:_____ DOB: _____ Phone: _____

Referring Physician: _____ Last Exam Date: _____

Reason for Evaluation

☐ OD

☐ OS

☐ OU

BCVA

OD: _____

OS: _____

Concern(s)

☐ Macular Degeneration

☐ Retinal Detachment / Tear

☐ Macular Hole

☐ Diabetic Retinopathy

☐ Other:_____

Priority

☐ Urgent 1–2 days (please call our office (605) 361-3937)

☐ Next Available 1–2 weeks

Other relevant findings or concerns:

_____

_____

Thank you for your referral and trusting us with your patient's care.