Ph: (208) 375-3871 **Fax**: (208) 321-1765 **Email**: office@treecityeyecare.com

Website: www.TreeCityEyecare.com

REFERRAL FORM

Date:___________ **Referring Doctor:**_____________________ **Office name/Phone:**________________________

Patient Information:

Name: ________________________ D.O.B: ______________ Phone: _________________

Insurance Information (If available)**:**

Medical Primary Insured name: ______________________ D.O.B: _______________

Med Insurance Provider: __________________________ ID#:___________________

Vision Insurance Provider: __________ Primary Insured Name: _____________________ ID#:________________

Reason for Referral:

- ☐ Specialty Contact Lens Evaluation
  - ☐ Keratoconus ☐ Corneal Scarring ☐ Corneal Transplant ☐ Dry Eye
  - ☐ Other: __________________
- ☐ Myopia Management/Orthokeratology Evaluation
- ☐ Ocular Surface Disease (Dry Eye) Evaluation
- ☐ Diabetic Retinal Evaluation
- ☐ Emergency Red Eye/Foreign body removal
- ☐ Glaucoma Evaluation
- ☐ InfantSEE
- ☐ Other (Please specify):____
- ☐ **Please refer patient back to our office for ongoing care**
- ☐ **Please keep patient at Tree City Eyecare for ongoing care**

Patient Medical Record Release to Tree City Eyecare

I authorize the release of my pertinent medical records to Tree City Eyecare: ____
(Patient Signature)

Please send referral form and all applicable medical records to (208) 321-1765.