AVERY EYE CLINIC
YOUR VISION IS OUR FOCUS

Referral / Consult Request

(936) 539 - 4500

Patient Name: _____

Date of Birth: _____

Address: _____

_____

Phone: _____

Email: _____

Insurance:_____

Insurance ID: _____

Will this be a Co-Managed Patient? *(Please circle one)* Yes No

Referring Doctor / Optometrist: _____

Office Phone: _____ Fax: _____

Office Contact Person: _____

I am referring the above patient to you for assistance with his/her eye care needs. Please evaluate the patient's eye problem / condition. *Reason for referral /consultation:*

_____

_____

_____

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_____

<u>Please fax Clinical Information / Office Notes to: (936) 286 – 3003</u>