Wyoming Center for Sight P.C.
Patient Referral Form

Please attach pertinent patient records and insurance cards ➡ fax: 307-237-7351

Central Appointment Line: 307-237-2511 **Please call for all urgent referrals**

Patient Name:	Referring physician:
Gender:	Practice name:
Address:	Phone(s):
City, State, Zip:	Fax:
Best Contact for scheduling:	Email:
Phone 1:	Address:
Phone 2:	City, State, Zip:
Primary language:	Office Contact:
Does the patient need an interpreter? ☐Yes ☐No	Primary Care Physician:
Guardian, if applicable:	PCP Phone:

Urgency, within: ☐ STAT (also call 307-237-2511) ☐ Time Sensitive: 1-2 weeks ☐ Next Available

Request for: ☐ Consult ☐ Second Opinion only ☐ Assume Care and Treatment

Reason for Referral/Consult:

Included in this fax are (check):

☐Demographics/Face-sheet
☐Insurance Card(front & back)
☐Recent visit/ Chart notes
☐Imaging
☐Other: _____

Fax completed form with attachments to 307-237-7351

Thank you for considering the home town team for your referrals!