PATIENT REFERRAL FORM

DOCTOR REFERRED TO:

PRINT NAME

ADDRESS

CITY / STATE / ZIP

PHONE NUMBER

REFERRED BY DOCTOR: _____ **O.D.**

PRINT NAME

ADDRESS

CITY / STATE / ZIP

PHONE NUMBER

REASON I am referring this patient to your office.

I will appreciate receiving a report of your findings.

Dr. Signature _____ O.D. Date _____

PATIENT:

PRINT NAME

AGE

ADDRESS

CITY/STATE/ZIP

PHONE NUMBER

PATIENT STATEMENT:

The reason I am being referred to another doctor as indicated on this Patient Referral Form has been discussed with me. I understand that it is my responsibility to make an appointment with the doctor referred to, giving him the white copy of this form when I keep my appointment. I hereby grant permission for the above named practitioners to exchange information from my case records.

Patient Signature: _____ Date: _____

WHITE: Patient will give to "Doctor Referred to"

YELLOW: Patient File