FLORIDA EYE
Microsurgical Institute, Inc.

Date:_____

REFERRAL FORM for SURGICAL/MEDICAL CONSULTATION

To:
- ☐ Randy S. Katz, M.D.
- ☐ Lee S. Friedman, M.D.*
- ☐ Barry A. Schechter, M.D., F.A.A.O.
- ☐ Jonathan S. Criss, M.D.
- ☐ Megan A. Rowlands, M.D., M.P.H.
- ☐ Steven M. Naids, M.D.

From Doctor: _____

Referral Office Address: _____

Phone Number for co-management questions: _____

Patient needs to be seen: ☐ ASAP ☐ 1-2 Weeks ☐ Next Available

Reason For Referral: ☐ Cataract Consultation ☐ Corneal Consultation ☐ Glaucoma ☐ Retinal Consultation ☐ Adult Strabismus ☐ Pediatric Consultation ☐ Other_____

Patient Information:

Demographics: Name _____

Insurance _____ Appt. Date/Time _____

Date of Birth _____ Phone # _____ Alt. Phone# _____

☐ Please call patient to make an appointment. ☐ Patient will call to schedule an appointment.

Medical:

Rx	OD _____	20/ _____	Refraction	OD _____	20/_____
	OS _____	20/ _____		OS_____	20/_____
	ADD _____	20/ _____		ADD _____	20/_____
Tonometry	OD _____		Medications:		
	OS _____			_____	
				_____	
				_____	

Comment and /or Instructions: _____

_____

_____

Physician Signature _____

Co-management Requested. ☐ YES ☐ NO

If surgical co-management is requested, are you on the patient's primary medical insurance? ☐ YES ☐ NO

Co-management subject to co-managing doctor's participation with insurance policy & insurance approval.

☐ *BOCA RATON: 9980 Central Park Blvd., Suite 204, Boca Raton, FL 33428 • (561) 451-4514*

☐ *BOYNTON BEACH: 1717 W. Woolbright Road, Boynton Beach, FL 33426 • (561) 737-5500*

☐ *WELLINGTON: 2575 S. State Road 7, Wellington, FL 33414 • (561) 792-1205*

Central Fax (561) 737-7055