eye clinic of wisconsin™
One vision. Yours.®

Practice: _____
Provider: _____
Address: _____
City/St/Zip_____
Phone: _____ Fax: _____

## Referral Request

Thank you for choosing the Eye Clinic of Wisconsin. **Please fax this form, insurance information, and clinical notes.**
Fax: 715.870.2401 Questions: 715.261.8548

| | | |
|---|---|---|
| Date | Form completed by | |
| Patient Name | | Date of birth |
| If minor, guardian's name | | |
| Patient's address/city/state/zip | | |
| Patient's phone number | Alternate number | |
| Insurance Plan: | ID# | Self-Pay ☐ |
| Diagnosis/Complaint | | Location requested |

Referral Purpose:

- ☐ General Consultation
- ☐ Glaucoma: Please send a copy of the patient's past visual fields.
- ☐ Low Vision: Please send any previous fundus photos and visual fields.
- ☐ Retina

Please describe the condition(s) to be evaluated and past ocular history: _____
_____
_____

Most Recent Refraction:
If applicable

| Sphere | Cylinder | Axis | Prism | Base | Add |
|---|---|---|---|---|---|
| | | x | | | |
| | | x | | | |

Best Corrected Visual Acuity
OD 20/_____
OS 20/_____

IOP: _____OD/_____OS

**Referring Provider Signature:** _____ **Date**: _____

**APPOINTMENT SCHEDULING**

☐ Please call the patient to schedule, note appointment below and fax back to my office.

| Date | Time | Provider | Location |
|---|---|---|---|