



Shannon Raines, COA, Referral Coordinator  
 Direct line: (352) 622-1728  
 Main Line: (352) 622-5183  
 Referral Fax: (352) 622-7552  
 Retina Referrals, Please Fax Here: (352) 291-5215

Referred from Dr. \_\_\_\_\_  
 Office contact: \_\_\_\_\_  
 Office phone: \_\_\_\_\_  
 Office fax: \_\_\_\_\_

**Patient Preferred Ocala Eye Office:**

- Magnolia - 1500 SE Magnolia Ext. Suite 106
- 200 West - 8520 SW State Road 200
- The Villages - 1950 Laurel Manor Dr. #250
- Paddock Park - 3130 SW 32nd Avenue
- Retina Consultants - 3130 SW 32nd Avenue

**Refer Patient To:**

- |   |  |
|---|--|
| <input type="checkbox"/> Mark A. Jank, M.D.<br><i>Cataract, Laser &amp; Refractive Surgery / Anterior Segment Disease</i>     | <input type="checkbox"/> Hina N. Ahmed, M.D.<br><i>Cataract &amp; Laser Surgery / Anterior Segment Disease</i>           |
| <input type="checkbox"/> John S. Deaton, D.O.<br><i>Cataract &amp; Laser Surgery / Anterior Segment Disease</i>               | <input type="checkbox"/> Robert J. Kraut, M.D.<br><i>Retina &amp; Vitreous Surgery</i>                                   |
| <input type="checkbox"/> Michael Morris, M.D.<br><i>Glaucoma &amp; Cataract Surgery / Anterior Segment Disease</i>            | <input type="checkbox"/> Vishwanath Srinagesh, M.D.<br><i>Cataract &amp; Laser Surgery / Comprehensive Ophthalmology</i> |
| <input type="checkbox"/> Chander N. Samy, M.D.<br><i>Retina &amp; Vitreous Surgery</i>  | <input type="checkbox"/> Hussain Elhalis, M.D.<br><i>Cornea / External Disease / Cataract &amp; Refractive Surgery</i>   |
| <input type="checkbox"/> Peter J. Polack, M.D.<br><i>Cornea, Cataract &amp; Refractive Surgery / Anterior Segment Disease</i> | <input type="checkbox"/> Charles F. Paglia, O.D.<br><i>Optometry / Contact Lenses</i>                                    |
| <input type="checkbox"/> Jodie A. Armstrong, M.D.<br><i>Cataract &amp; Laser Surgery / Anterior Segment Disease</i>           | <input type="checkbox"/> Kathryn Mar Jip Pomakis, O.D.<br><i>Optometry / Contact Lenses</i>                              |
| <input type="checkbox"/> Mohammed K. ElMallah, M.D.<br><i>Cataract &amp; Glaucoma Surgery / Anterior Segment Disease</i>      |  |

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient Insurance: \_\_\_\_\_

Will we co-manage this patient: Yes \_\_\_\_\_ No \_\_\_\_\_

Reason for referral:

- |  |   |
|--|---|
| <input type="checkbox"/> Cataract Evaluation | <input type="checkbox"/> Retina Evaluation          |
| <input type="checkbox"/> Eye Lid Evaluation  | <input type="checkbox"/> LASIK / Refractive Surgery |
| <input type="checkbox"/> Glaucoma Evaluation | <input type="checkbox"/> Other: _____               |
| <input type="checkbox"/> Cornea Evaluation   | _____   |

Manifest Refraction OD \_\_\_\_\_ VA \_\_\_\_\_ OS \_\_\_\_\_ VA \_\_\_\_\_

Add \_\_\_\_\_ J \_\_\_\_\_ Add \_\_\_\_\_ J \_\_\_\_\_

<b>OD</b>	<b>OS</b>
IOP: _____	IOP: _____
Remarkable Findings:	Remarkable Findings:

How soon would you like the patient to be scheduled with Ocala Eye? \_\_\_\_\_

Referring Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_