OD Referral Form

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
- ☐ Heath Brook - 4414 SW College Road, Suite 1462

Refer Patient To:

- ☐ Mark A. Jank, M.D. *Cataract, Laser & Refractive Surgery / Anterior Segment Disease*
- ☐ John S. Deaton, D.O. *Cataract & Laser Surgery / Anterior Segment Disease*
- ☐ Michael Morris, M.D. *Glaucoma & Cataract Surgery / Anterior Segment Disease*
- ☐ Chander N. Samy, M.D. *Retina & Vitreous Surgery*
- ☐ Peter J. Polack, M.D. *Cornea, Cataract & Refractive Surgery / Anterior Segment Disease*
- ☐ Jodie A. Armstrong, M.D. *Cataract & Laser Surgery / Anterior Segment Disease*
- ☐ Mohammed K. ElMallah, M.D *Cataract & Glaucoma Surgery / Anterior Segment Disease*
- ☐ Hina N. Ahmed, M.D. *Cataract & Laser Surgery / Anterior Segment Disease*
- ☐ Robert J, Kraut, M.D. *Retina & Vitreous Surgery*
- ☐ Vishwanath Srinagesh, M.D. *Cataract & Laser Surgery / Comprehensive Ophthalmology*
- ☐ Hussain Elhalis, M.D. *Cornea / External Disease / Cataract & Refractive Surgery*
- ☐ Charles F. Paglia, O.D. *Optometry / Contact Lenses*
- ☐ Kathryn Mar Jip Pomakis, O.D. *Optometry / Contact Lenses*
- ☐ Vivi Fretland, O.D. *Optometry / Contact Lenses*
- ☐ Sarah Kim, D.O. *Oculoplastics / Aesthetics*

Patient Name: _____ Date: _____

Address: _____

Date of Birth: _____ Phone #: _____

Patient Insurance: _____

Will we co-manage this patient: Yes_____ **No**_____

Reason for referral:

- ☐ Cataract Evaluation
- ☐ Eye Lid Evaluation
- ☐ Glaucoma Evaluation
- ☐ Cornea Evaluation
- ☐ Retina Evaluation
- ☐ LASIK / Refractive Surgery
- ☐ Other _____

Manifest Refraction OD _____ VA _____ OS _____ VA _____

Add _____ J _____ Add _____ J _____

OD	OS
IOP:____	**IOP:**____
Remarkable Findings:	**Remarkable Findings:**

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

Referring Doctor Signature: _____ **Date:** _____