OD Referral Form

OcalaEye

Main Line: (352) 622-5183
Referral Fax: (352) 622-7552
Retina Referrals, Please Fax: (352) 291-5215

Chelsea Crile—Physician Liaison
ccrile@ocalaeye.com
Direct Line: (352) 351-7155

Referred from Dr._____
Office Contact:_____
Office Phone:_____
Office Fax:_____

Refer Patient To:

- ☐ Michael Morris, M.D. *Premium Cataract & Refractive Surgery, Glaucoma Surgery, Anterior Segment Disease*
- ☐ Peter J. Polack, M.D. *Premium Cataract & Refractive Surgery, Cornea, Anterior Segment Disease*
- ☐ Jodie A. Armstrong, M.D. *Premium Cataract & Refractive Surgery, Anterior Segment Disease*
- ☐ Mohammed K. ElMallah, M.D. *Premium Cataract & Refractive Surgery, Glaucoma Surgery, Anterior Segment Disease*
- ☐ Hina N. Ahmed, M.D. *Premium Cataract & Refractive Surgery, Anterior Segment Disease*
- ☐ Vishwanath Srinagesh, M.D. *Premium Cataract & Refractive Surgery, Comprehensive Ophthalmology*
- ☐ Hussain Elhalis, M.D. *Premium Cataract & Refractive Surgery, Cornea, External Disease*
- ☐ Chander N. Samy, M.D. *Retina & Vitreous Surgery*
- ☐ Robert J. Kraut, M.D. *Retina & Vitreous Surgery*
- ☐ Sarah Kim, D.O. *Oculoplastics / Aesthetics*

Patient Preferred Ocala Eye Office:

- ☐ 200 West (Ocala) - 8520 SW State Road 200
- ☐ Heath Brook (Ocala) - 4414 SW College Rd, Suite 1462
- ☐ Dunnellon - 11352 N. Williams St, #201A
- ☐ The Villages - 1950 Laurel Manor Dr. #250
- ☐ Spanish Plaines (The Villages) - 1556 Bella Cruz Drive
- ☐ Fenney (The Villages/Wildwood) - 4508 Warm Springs Ave

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 Lens Exchange
- ☐ Other_____

Manifest Refraction OD_____ VA_____ OS_____ VA_____

Add _____ J _____ Add _____ J _____

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

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

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