The Retina Center of Western Colorado

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Please fill in as much information as possible and FAX to 970 255 7076. We will contact the patient and return this form to you as confirmation.

PT NAME: _____ DOB: _____

ADDRESS: _____ PHONE: _____
MAILING CITY STATE ZIP

REFERRING DOCTOR: _____ DOCTOR'S PHONE: _____

SUSPECTED PROBLEM (Please circle all that apply) RIGHT LEFT

MACULAR DEGENERATION: WET DRY INDETERINATE

DIABETIC RETINOPATHY EDEMA RETINAL DETACHMENT

RETINAL TEARS FLASHES AND FLOATERS LATTICE

MACULAR HOLE EPIRETINAL MEMBRANE VEIN OCCLUSION

PRE CATARACT/LASIK EXAM OTHER: _____

FOUND ON ROUTINE EXAM? YES NO DIABETIC? YES NO

HOW LONG HAS VISION BEEN REDUCED? _____

Va OD: _____ Va OS: _____ IOP: OD _____ OS _____

INSURANCE: _____

RECEIVED: _____ DATE: _____

PATIENT'S APPOINTMENT AT THE RETINA CENTER: _____