Carolinas Eye Center

Where your time and vision truly matter.

PROVIDER REFERRAL FORM

Date: _____

Physician Requested: _____

REFERRAL PRIORITY REQUEST

- ☐ Emergency – *Please call the office directly*
- ☐ Urgent – Within 7 Days
- ☐ Next Available

☐ Please Fax Appointment Confirmation

Referring Provider Information (Required)

Name: _____

Practice Name: _____

Address: _____

Provider's Email: _____

Phone: _____ Direct Fax: _____

Patient Information (Required)

☐ ATTACH DEMOGRAPHIC SHEET → Attach Demographic Sheet only if all patient's personal information as listed has been provided. **Please make sure all of the information as requested is provided.**

Patient Name: _____

Patient Address: _____

Phone #1: _____ Phone #2: _____

D.O.B.: _____ Primary Insurance: _____

Language: _____ Race: _____ Ethnicity: _____ Gender: ☐ Female ☐ Male

Reason for Referral/Consult: _____

_____

Diagnosis: _____

Additional Remarks: _____

_____

Please include only the exam notes pertinent to this appointment with this fax. Number of pages attached: _____

THIS SECTION TO BE COMPLETED BY OUR OFFICE AND WILL BE RETURNED TO YOUR PRACTICE, TO THE FAX NUMBER YOU PROVIDED.

Appointment Date: _____ Time: _____

Provider: _____ Location: Carolinas Eye Center

PHONE 704-510-3100

FAX 980-498-3839

WEBSITE CarolinasEyeCenter.com

To ensure this patient's appointment can be made, please complete this form.

All information must be clearly identified and we will contact your patient for an appointment within 48 hours.

We will notify you of their appointment if a fax number is provided.