*Anderson Eye Care*

*2890 Ventura St*
*Anderson, CA 96007*

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# Prior Referral Request Form

To PCP/Facility: ________________________________________________ Phone#:____________________________

Address: _________________________________________________________ Fax#: ______________________________

Patient Name: ____________________________________________________ Patient DOB: ______________________

Anticipated Appt. Date: __________________________________________ with Dr. ____________________________

The above patient carries an insurance that may need a prior referral or authorization as they may be enrolled in a managed care plan. The necessary referral or authorization is needed before our ophthalmologist is able to see them for this visit.

Along with a complete annual eye exam and refractive error checks, our ophthalmology services may also include various eye testing and examination services when patient may show such indications of:

| | | |
|---|---|---|
| Diabetic Retinopathy | Strabismus | Pterygium |
| Retinopathy of Prematurity | Dermatochalasis | Herpetic Eye Infection |
| Cataracts | Eye Pain | Retinal Detachment |
| Glaucoma | Corneal Scar or Ulcer | Age Related Macular Degeneration |
| Amblyopia | Foreign Body in Cornea | |
| Nystagmus | Dry Eye Syndrome | |

## Examples of possible additional testing may include:

- Dilated Fundus Exam
- External Photography
- Topography
- Fundus Photography
- Ocular coherence Tomography (OCT)
- Ultrasonography A-Scan/ B-Scan
- Visual Field Examination
- Sensorimotor Exam

_______________________________ Referring Physician Signature

_________________________________ Referring Physician NPI #

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