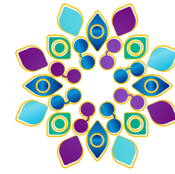
Carolina

CHILDREN'S EYE CARE, PA



Referral Form

PATIENT

NAME: ____

DOB: ______/________/_______

ADDRESS:____

PARENT/GUARDIAN NAME:____________________________________

RELATIONSHIP: mother father foster other_______________

PHONE NUMBER(S): MOBILE (_______)______-________

OTHER (_______)______-________

DIAGNOSIS (actual or suspected): Blurry Vision per child/parent

Failed Vision Screen Tearing Eye(s) Red Eye(s)

Cataract Strabismus Ptosis

Other:____

REFERRING PROVIDER

NAME: __________________________________ MD DO NP PA

SPECIALTY: Pediatrics Family Med Other_____________________

PHONE NUMBER:(_______)______-________

FAX NUMBER:(_______)______-________

Please fax most recent office records and applicable labs, along with this cover sheet, to **(336) 252-2087**. Please send relevant imaging with the patient.

IF AN URGENT APPOINTMENT IS BEING REQUESTED, PLEASE MARK NOTES URGENT, FAX NOTES AND CALL (336) 252-2085. WE CANNOT BE RESPONSIBLE FOR URGENT REFERRALS UNLESS YOU HAVE DISCUSSED THE PATIENT DIRECTLY WITH OUR OFFICE.

The referring provider's office will be contacted with the scheduled appointment time **AFTER** notes are reviewed by a physician.

Please have the REFERRING OFFICE/ PARENT/PATIENT CALL (336)252-2085 to register the patient and schedule the appointment.

Thank you for choosing Carolina Children's Eye Care!

Phone: 336-252-2085 • Fax: 336-252-2087
3608 W Friendly Ave • Suite 101 • Greensboro, NC • 27410
www.carolinakidseyecare.com