Verdier Eye Center

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VerdierEyeCenter.com

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Radwa Elsharawi, M.D.
Troy L. Fox, O.D., F.A.A.O.
Brittany A. Darnley, O.D.
Jordan L. Marentette, O.D., F.A.A.O.
Derek M. Phelps, O.D.

PATIENT REQUEST FOR EVALUATION REFERRAL

We look forward to working with you to help address your patient's eye health needs.
If you're experiencing a medical emergency, please call 911.

Verdier Eye Center is a referral-based practice. Together, we can deliver exceptional patient care.
To refer a patient, please complete the online referral form below.

Please Fax with Form: Physician Notes/Letter and Diagnostic Tests

Failure to fill out the entire form or attach proper information will result in a delay of processing an appointment.

Type of Appt: ☐ Urgent ☐ Routine Date: _____

Patient Information

Patient Name *(Legal Name)* : _____ Date of Birth:_____ Sex:_____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact:_____ Relationship: _____ Phone: _____

Primary Care Physician *(First and Last Name)* : _____ ☐ MD ☐ OD

Does the patient currently reside in a Skilled Nursing Home, Assisted Living Facility or Group Home?

☐ No ☐ Yes, please indicate the place of residence: _____

Is an Interpreter Needed? ☐ No ☐ Yes, language: _____

Reson for Referral (diagnosis): _____

Referring to: ☐ David D. Verdier, M.D. ☐ Karl J. Siebert, M.D. ☐ Ann M. Renucci, M.D. ☐ Kyle B. McKey, M.D. ☐ Roman I. Krivochenitser, M.D.
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Medical Insurance Information (Attach Copies of Insurance Card(s)):

Primary Insurance: _____ Policy#:_____

Secondary Insurance:_____ Policy#:_____

Referring Physician Information:

Referring Physician *(First and Last Name)*: _____ ☐ MD ☐ OD NPI#: _____

Address: _____ City: _____ State:_____ Zip:_____

Phone:_____ Fax: _____ Person filling out form: _____

OFFICE USE ONLY:

Appointment Date and Time:_____

Chart #:_____ Initials: _____ Date and time faxed back:_____