Patient Referral Form

retina CARE CENTER

ADAM AUFDERHEIDE, MD, PhD
LISA LEISHMAN, MD

Patient Full Name: Date:

Phone (home): Work: Cell:

Address: City, State & Zip:

Date of Birth: Sex: ☐ Male ☐ Female

Is this visit the result of an accident:

If yes, please explain:

INSURANCE: ☐ Commercial ☐ Worker's Compensation ☐ Motor-Vehicle Accident

Primary Insurance Name: Insurance Phone:

ID/Claim No.: Group: Date of Injury:

Secondary Insurance: ID No.: Group:

Please be advised that some insurances require prior authorization.

REFERRING PHYSICIAN

Referring Physician: Phone: Fax:

City: State: Zip: NPI:

REASON FOR REFERRAL

Symptoms/Patient Complaints:

Diagnosis:

Other Comments:

Please send a copy of the following documents: Current Examination Notes Copy of Insurance Cards

We have two office locations for your convenience, please select preferred location:

☐ Medford Office
748 State St
Medford, OR 97504
541 842 2020

☐ Grants Pass Office
1236 NE 7th St
Grants Pass, OR 97526
541 842 2020

Please fax to 541 842 2022 and we will contact the patient. Thank you!