1211 Coolidge Blvd, Suite 401 P (337) 541-1700

Lafayette, La 70503 F (337) 534-4992

**PATIENT REFERRALS**

DATE :

PATIENT NAME : DATE OF BIRTH :

PHONE :

ADDRESS:

Insurance:

\*\*Please note, we do not accept Medicaid as primary or Wellcare

**REASON FOR REFERRAL:** PLEASE CIRCLE

GLAUCOMA EVAL CATARACTS ROUTINE EYE EXAM OTHER

REFERRING PHYSICIAN:

OFFICE NUMBER: FAX:

PLEASE SEND REFERRAL ALONG WITH: PT DEMOGRAPHICS / FACE SHEET

MEDICAL INSURANCE CARDS

LAST OFFICE NOTES

MOST RECENT VISUAL FIELD

OCT TESTING

ANY OTHER GLAUCOMA SPECIFIC DIAGNOSTIC TESTING PERFORMED

Visual field NOT performed at our office

OCT not performed at our office

**Fax all records to (337) 534-4992, except OCT’s. We must have color copies emailed or mailed**

**\*\*If an optic nerve OCT has been performed, please mail the color original or email it to** [**office@julieforemanmd.com\*\***](mailto:office@julieforemanmd.com**)

Appointments will not be made until we have all records or have been notified that they have not been performed

Thank you, and as always, it is a pleasure working with you in the care of your patients.