COLORADO RETINA
P: (303) 261-1600
F: (303) 261-1601
info@retinacolorado.com

For same-day triage assistance
Text our Curbside Consult line 720-738-4744

REFERRAL FORM

PATIENT INFORMATION

* Full Name (Last, First, MI) : _____
*Use **legal** name as listed on ID*

* Diagnosis :

Symptoms & Length of Symptoms :

Relevant Medical History and Other Notes for CRA :

Urgency of Referral : ☐ 48 Hours ☐ Within 1 Week ☐ Patient Preference

For ocular emergencies or patients that need to be seen same-day, call us ASAP.

Affected Eye : ☐ Right OD ☐ Left OS ☐ Both

Date of Birth : _____/_____/_____ Sex : ☐ Male ☐ Female

* Phone Number : _____ *Preferred phone # required to contact patient.*

E-Mail *optional* : _____

REFERRING PROVIDER INFORMATION

* Provider Name : _____ Designation : _____

Practice Name : _____

Practice City : _____ State : _____

Phone : _____ Fax : _____

APPOINTMENT PREFERENCES

Requested CRA Provider(s) : _____

Perferred Location :
☐ Central Park Denver, CO ☐ Cherry Creek Denver, CO ☐ Lafayette, CO
☐ Patient Preference First Available ☐ Lakewood, CO ☐ Littleton, CO ☐ Parker, CO

* IMPORTANT: Fax below files to 303-261-1601

✓ Patient Demographics ✓ Insurance Cards ✓ Recent Exam Notes ✓ Imaging