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

Need 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* : _____

PROVIDER INFORMATION

* Provider Name : _____ Designation : _____

Practice Name : _____

Practice City : _____ State : _____

Phone : _____ Fax : _____

APPOINTMENT PREFERENCES

Requested CRA Provider : _____

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

IMPORTANT: FAX below files to (303) 261-1601 OR EMAIL to info@retinacolorado.com

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