REFERRAL FORM

Please complete this form AND fax or send via secure e-mail (IEOROI@spokaneeye.com) with chart notes and COLOR OCT or photos.
We will contact your patient directly to schedule an appointment with one of our physicians.

☐ **URGENT (within 24 hours)** ☐ **NEXT AVAILABLE APPT.**

APPOINTMENTS ALL LOCATIONS
509-456-0107

TOLL FREE:
800-824-0664

REFERRAL FAX LINE:

509-747-2635

☐ Cornea
☐ Glaucoma
☐ Pediatrics
☐ Genetics
☐ Adult Strabismus
☐ Cataract or YAG Evaluation
Co–Managed? Yes ☐ or No ☐
☐ Comprehensive Eye Exam
☐ Other

RETINA REFERRALS
☐ Diabetic Retinal Changes
☐ Macular pucker / hole
☐ Retinal Edema
☐ Macular Degeneration
☐ Vascular Occlusion
☐ Retinal tear or detachment (RD)
(For tear or RD, *Call TRIAGE at (509) 623-9760)*
☐ Other _____

PATIENT INFORMATION

(Lack of complete patient information and/or lack of exam notes could result in a delay in processing this referral) Please send color OCT or photos to IEOROI@spokaneeye.com via secure e-mail.

Patient: _____ __ _____ _____
First M/I Last

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

Address: _____

City / State / Zip: _____

Patient Preferred Phone #: _____

INSURANCE INFORMATION ** Please include copies of current insurance cards

Insurance Name: _____

ID #: _____ Group #: _____

Subscriber's Name: _____

Subscriber's Date of Birth: ___ / ___ / ___ Patient Relationship to Subscriber: _____

NOTICE TO PATIENTS: Please consult with your health plan regarding health benefit restrictions, limitations, and process for scheduling services. A referral does not equal an agreement of payment for services. All claims are subject to policy limitation and plan requirements. It is the patient's responsibility to consult with his or her primary care physician before scheduling any procedures not authorized above.

03.50a . Scheduling: Referral Form
Created date: 9.25.2023 JHS
Approval: Patient Care Systems Manager