SOCO EYE SPECIALISTS

Fax to719.934.9657

Referral Form

Referring Doctor, Practice

Patient Name	DOB
Address	
Phone	e-mail
Alt Phone	

	Emergency <2 days		Urgent 1 week		Next available

Reason for consult/concern

Please include Exam notes, Refraction, Demographics or ID and Insurance cards

If referring for testing only

Billable Diagnosis Code	
Do you have a unique desired report?	

✓	OCT	Macula/Nerve
	B Scan	OD/OS/OU
	Visual Field	10/24/24c/30/other

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