SOCO EYE SPECIALISTS

Fax to719.257.3959

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	24-2c
☐		

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