

### Division of Ophthalmology Referral Request

Division Phone: 714-509-4490

CHOC Scheduling Line 1-888-770-2462

Fax: 1-855-246-2329

Thank you for referring your patient to the Division of Ophthalmology.

#### Patient Information

Does the patient live with someone other than the legal guardian?  No  Yes, relationship \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Parent Phone: \_\_\_\_\_

Insurance: \_\_\_\_\_ Parent Cell: \_\_\_\_\_

**1. Is this an emergent Ophthalmology referral?**  No  Yes **If yes, requires a phone call from an MD /PA /NP**

**with clinical information to 714.509-4490**

**2. Please describe the patient's chief complaint and include onset and laboratory results:**

---



---



---

**3. What is the key question you want us to answer?**

---



---



---

**To expedite appointment scheduling, please provide the following by FAX 1-855-246-2329:**

- This completed form**
- Medical records related to the chief complaint**
- Pertinent laboratory results**
- Patient demographics**
- Authorizations 99245 Consult, or 99205 New Patient, 92250 Fundus photography, 92015 Refractory, 92060 Ophthalmological Service, or if not applicable a copy of insurance card**

Referring Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Provider Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_