

FLORIDA RETINA SPECIALISTS

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Patient Referral Form

PATIENT INFORMATION

Appointment Date

Date of Birth

Name (Last, first, middle initial)

Street address, City, ST, ZIP Code

Primary Phone/ Other phone number

Medical Insurance:

Type of Referral

- Diabetic retinopathy Possible retinal tear/detachment Infection
 Macular Degeneration Inflammation Other _____

Please describe nature of patient complaint. Please attach additional medical examination, if applicable.

Referring Doctor

Practice Name

Practice Fax

Practice Phone

Referring Physician Name

Referring Physician Signature

Date

PLEASE CIRCLE WHICH OFFICE YOU ARE

REFERRING TO:

MERRIT ISLAND OFFICE:
280 N Sykes Creek Pkwy, Suite B
Merritt Island, FL 32953
321-735-8800
321-735-8898 fax

VIERA OFFICE:
2329 Medico Ln
Suite 103
Melbourne, FL 32940
321-735-8800
321-690-2288 fax

