FLORIDA RETINA SPECIALISTS
Dr. Frank Venzara, III

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FloridaRetinaSpecialists@gmail.com

Patient Referral Form

PATIENT INFORMATION

Appointment Date

Name (Last, first, middle initial)

Date of Birth

Street address, City, ST, ZIP Code

Primary Phone/ Other phone number

Type of Referral

☐ Diabetic retinopathy
☐ Macular Degeneration
☐ Possible retinal tear/detachment
☐ Inflammation
☐ Infection
☐ Other_____

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

Referring Doctor

Practice Name

Practice Fax

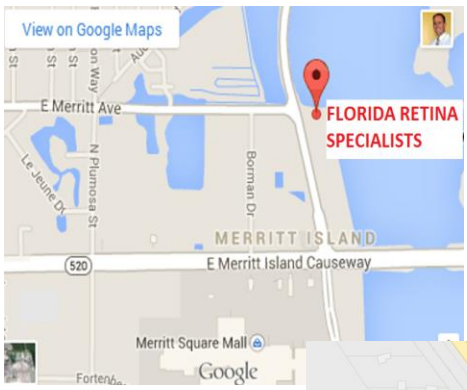
Practice Phone

Referring Physician Name

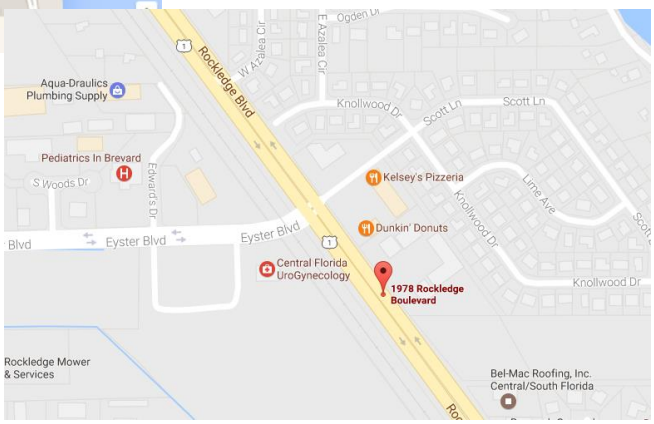
Referring Physician Signature

Date

PLEASE CIRCLE WHICH OFFICE YOU ARE REFFERRING TO:



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



ROCKLEDGE OFFICE:
1978 Rockledge Blvd (U.S. 1)
Suite 105
Rockledge, FL 32955
321-690-1800
321-735-8898 fax