FLORIDA RETINA SPECIALISTS

NEW PATIENT REFERRAL FORM

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PATIENT INFORMATION

Appointment Date	Date of Birth	Patient Phone	Alternate Phone

Patient Name (Last, First, Middle Initial)	
Street Address	**City / State / ZIP**
Medical Insurance Company	**Member number**
Secondary Insurance Company	**Member number**

TYPE OF REFERRAL

☐ Diabetic retinopathy	☐ Possible retinal tear / detachment	☐ CRVO / BRVO
☐ Macular degeneration	☐ Floaters / vitrectomy	☐ Valeda PBM
☐ Other:		

If urgent, please call 321-735-8800 to speak with a receptionist

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

REFERRING DOCTOR

Referring Doctor / Practice Name	Practice Phone	Practice Fax

Referring Physician Name	Date
Referring Physician Signature	

PREFERRED OFFICE

☐ MERRITT ISLAND OFFICE
280 N Sykes Creek Pkwy, Suite B
Merritt Island, FL 32953
Phone 321-735-8800 • Fax 321-735-8898

☐ VIERA OFFICE
2329 Medico Ln, Suite 103
Melbourne, FL 32940
Phone 321-735-8800 • Fax 321-690-2288

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