Southern Eye Associates

www.southern-eye.com

DATE:_____

Direct physician referral phone: 864-269-4750
Direct physician referral fax: 844-965-9275

OPHTHALMOLOGY CONSULTATION / REFERRAL FORM:

Patient's Name: _____ **DOB:** _____

Phone:_____ **Cell:**_____ **Contact:**_____

Emergency ☐ **Routine** ☐

This patient is being referred to:

☐ First Available
☐ Bradley B. Williams, MD
☐ Kurt F. Heitman, MD
☐ Steven E. Civiletto,MD
☐ Douglas W. Stokes, MD
☐ Wade A. Reardon, MD
☐ Craig A. Odell, OD
☐ Jeffrey V. Swearingen.OD
☐ Stanley T. Pace, MD
☐ Andrew E. Hack, MD
☐ William R. Steigerwald OD

Reason for referral: _____
(Please fax any pertinent medical records)
Referred By: _____

Name of person submitting this referral on behalf of the physician: _____

Referring Physicians Fax Number: _____ Telephone Number: _____

Please fax a copy of the patient's Medical Records, Last chart note and Insurance cards

For Southern Eye Use Only:

☐ Appointment Scheduled:
Date: _____Time:_____ AM/PM **Physician**: _____
Location: ☐ Greenville ☐Greer

☐ Appointment NOT Scheduled: Unable to contact the patient after several attempts.
1st Attempt Date: _____2nd Attempt Date: _____ 3rd Attempt Date: _____