Evans & Taylor Eye Care
Medical Referral Form

Main Office: 765-447-4951
Fax: 765-447-4834

____/____/_____
Date

Patient Name: _____

Date of Birth: _____ Medical Insurance: _____

Patient Phone: _____ Policy #: _____

Does the patient have a history of any of the issues listed:

- ○ Glaucoma
- ○ Cataracts
- ○ Macular Degeneration
- ○ Eye Discoloration
- ○ Eye Pain
- ○ Headaches
- ○ Concussion
- ○ Stroke
- ○ Visual discomfort while reading or using computer
- ○ Diabetes
- ○ Eye Injury: _____
- ○ Other: _____
- ○ Poor Balance
- ○ Double vision
- ○ Poor Memory
- ○ Visual Snow

Provider Contact Information

Referring Provider: _____ Phone: _____

Practice Name: _____ Office Phone: _____

Address: _____

City: _____ Zip Code: _____

Description

Please provide a brief description of the patient's symptoms and the reason for referral or include your exam notes:

_____

_____

_____

_____

_____

_____

○ **Would you like a copy of our exam findings?**