

# Referral Form

**IF THIS IS AN EMERGENCY/ SAME DAY REQUEST  
PLEASE CALL THE OFFICE AT (706) 543-3200, Option 5  
Fax #: (706) 433-1745**

Patient Demographics:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alt. Phone #: \_\_\_\_\_

Insurance Plan: \_\_\_\_\_ ID #: \_\_\_\_\_

**(Please send a copy of the front and back of insurance card with request)**

Referring Doctor: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

**Reason For Referral:** \_\_\_\_\_

**Patient's Current Vision:** \_\_\_\_\_ OD \_\_\_\_\_ OS

Please fax referring office notes (including Lab Test Results), along with this cover sheet to (706) 433-1745.

Please ensure that the patient brings a photo ID, insurance cards, and a current list of medications to the scheduled appointment.

**Thank you for choosing Athens Retina Center!**

ARC Office Use Only:

Notes Received From Referring:  Yes  No Appointment Date: \_\_\_\_\_

Appointment Scheduled with Dr:  Iyer  Copeland Appointment Time: \_\_\_\_\_

Informed Referring About Appt By:  Phone  Fax on \_\_\_\_\_ at \_\_\_\_\_  
(Date) (Time)

Handled By ARC Employee: \_\_\_\_\_