ATHENS RETINA CENTER
COMMUNITY DRIVEN | COMPASSIONATE CARE

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** ☐ **Carroll** Appt. Time:_____

Informed Referring About Appt By: ☐ **Phone** ☐ **Fax on** _____ **at** _____.
(Date) (Time)

Handled By ARC Employee:_____