



Athens Clinic

1620 Prince Ave

Athens, GA 30606

Phone 706.546.0170 | Fax 706.546.5015

Patient Referral

Patient _____

Patient Date of Birth _____

Home or Cell Phone _____

Email Address _____

Patient Address _____

INSURANCE INFORMATION

(Please attach demographics and insurance cards)

Primary Insurance _____

Policy Number _____

Reason for Referral

- | | |
|---|---|
| <input type="checkbox"/> Blurry or Decreased Vision | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Irritation/Discomfort | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Surgical Evaluation | <input type="checkbox"/> Visual Disturbance |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dry Eyes/Allergies | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Retina Evaluation | <input type="checkbox"/> Uveitis |

Other _____

Routine or Medically Urgent

Refer to

- Centrael Evans, M.D.
- Stephanie K. Lynch, M.D.
- Tirth J. Shah, M.D.
- Sejal Patel, O.D.

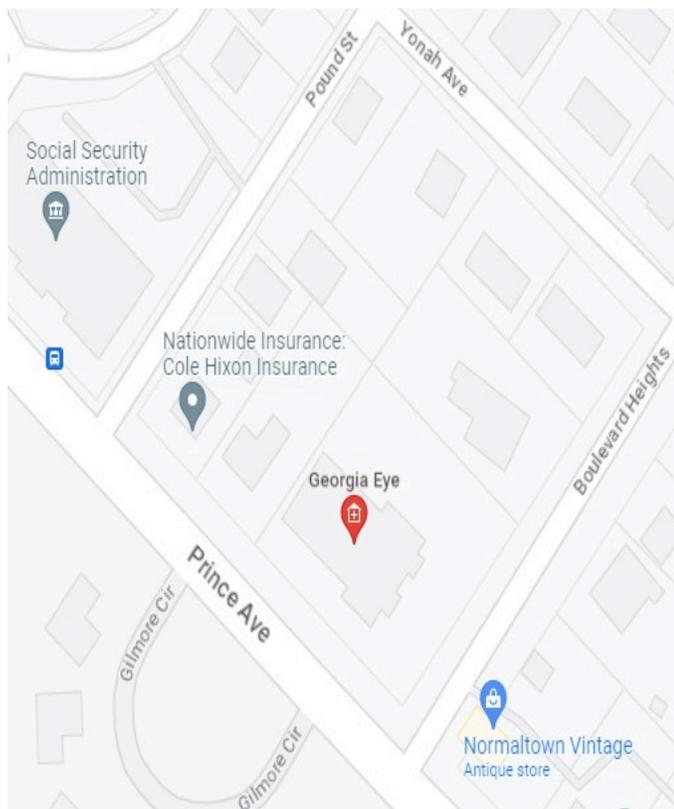
Referring Physician

Referring Physician _____

Contact at office _____

Phone _____

Comanage? Yes / No



Thank you for your referral!