Georgia Eye

GeorgiaEyeClinic.com

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

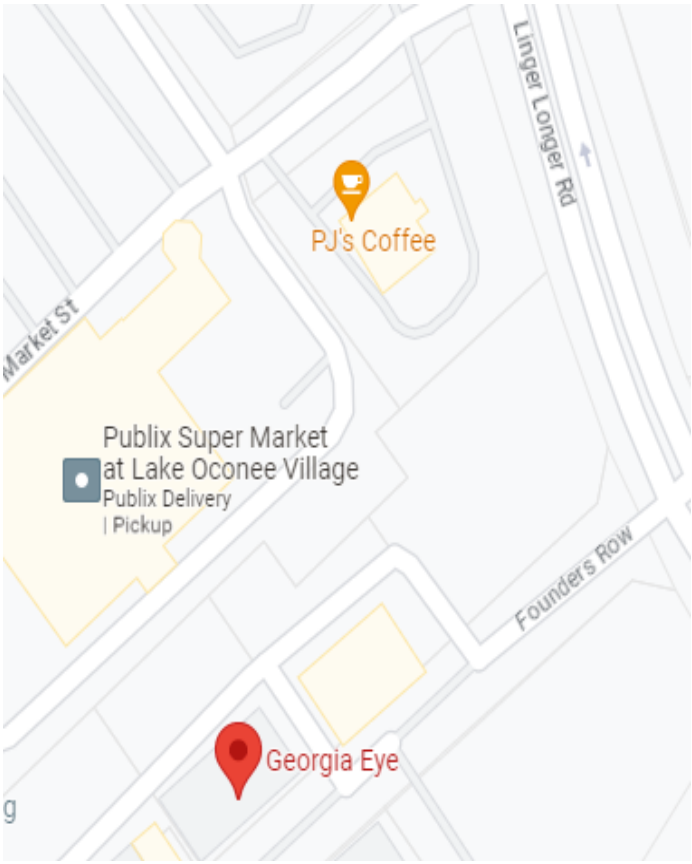
- ▢ Blurry or Decreased Vision
- ▢ Irritation/Discomfort
- ▢ Surgical Evaluation
- ▢ Cataracts
- ▢ Dry Eyes/Allergies
- ▢ Retina Evaluation
- ▢ Glaucoma
- ▢ Macular Degeneration
- ▢ Visual Disturbance
- ▢ Diabetes
- ▢ Eye Pain
- ▢ Uveitis

Other_____

▢ **Routine** **or** ▢ **Medically Urgent**

Greensboro Clinic

1030 Founders Row, Suite C
Greensboro, GA 30642
Phone 706.546.0170 | Fax 706.546.5015



Refer to

- ▢ Centrael Evans, M.D.
- ▢ Tirth J. Shah, M.D.

Referring Physician

Referring Physician _____

Contact at office_____

Phone_____

Comanage? Yes ☐ No ☐

Thank you for your referral!