Midwestern University
Eye Institute
5865 W. Utopia Rd.
Glendale, AZ 85308
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Optometry / Ophthalmology Referral Form

Instructions:

Please fax this form, **ALONG WITH ANY PATIENT RECORDS**, to fax number: **623-806-7255.** Required fields are indicated with an asterisk (*).

This form is not intended for emergency referrals. Please contact us directly at 623-806-7272 for emergencies.

Ophthalmology Anterior Segment (please check all that apply)*:

- ☐ Anterior Segment Consultation & Procedures (ex: YAG, cautery, etc.)
- ☐ Cataract Consultation
- ☐ Corneal Consultation and Procedures
- ☐ Cross Linking (CXL) Treatment for Keratoconus
- ☐ Lasik Evaluation/Refractive Surgery Evaluation
- ☐ Other: _____

Pediatric Ophthalmology and Adult Strabismus (please check all that apply)*:

- ☐ Adult Strabismus / Double Vision
- ☐ Child Strabismus
- ☐ Medical Diagnosis or Syndrome Requiring Eye Exam
- ☐ Strabismus Surgery Evaluation
- ☐ Blocked Tear Duct, Ptosis, Eyelid Lesion
- ☐ Other Ocular Finding or Concern: _____

Reason for Referral/Pertinent Clinical Findings*:

_____

_____

_____

Patient Information:

Patient's Name*:_____

Date of Birth*:_____ Phone Number*: _____

Insurance*:_____ Referral Date*: _____

Referring Provider:

Referring Physician*: _____

Office Address*: _____

Phone Number*:_____ Fax*:_____ Date*: _____

Would you like us to contact the patient for an appointment: ◯ Yes ◯ No
The patient has been scheduled on: _____

We kindly thank you for your referral