Midwestern University Eye Institute

5865 W. Utopia Rd.
Glendale, AZ 85308
Phone: (623) 537-6000
Fax: (623) 806-7210

Please fax this form, **ALONG WITH ANY PATIENT RECORDS**, to: **623-806-7210**

This form is not intended for emergency referrals.

For Emergency Referrals please contact us directly at 623-537-6000.

Referred for:

- ☐ **Primary/Routine Eye Care**
- ☐ Ocular Disease
- ☐ Diabetic Eye Exam
- ☐ Electrodiagnostics
- ☐ Plaquenil Screening
- ☐ Dry Eye
- ☐ Diagnostic Testing
- ☐ Binocular Vision/Vision Therapy/Strabismus
- ☐ Acquired/Traumatic Brain Injury/Concussion
- ☐ Pediatrics/School Eye Exam
- ☐ Sports Vision Performance
- ☐ Specialty Contact Lens
- ☐ Myopia Control/ Management
- ☐ Ocular Prosthetics
- ☐ Low Vision/Visual Rehabilitation
- ☐ Other:_____

Reason for referral/pertinent clinical findings:

_____

_____

_____

Patient Information:

Patient's Name: _____

DOB: _____ Phone Number: _____

Insurance: _____ Referral Date: _____

Would you like us to contact the patient for an appointment? ☐ Yes ☐ No

The patient has been scheduled on _____

Referring Physician:_____

Office Address: _____

Phone Number:_____ Fax Number:_____

Date:_____

We kindly thank you for your referral