PATIENT REFERRAL FORM

Lakeshore Eye Physicians
Howard Reinglass, MD
7200 N. Western Avenue
Chicago, Illinois 60645-1812

Today's Date: _____2009

PATIENT INFORMATION

Name _____
First Last MI

Phone: _____-_____-_____ Date of Birth: _____-_____-_____

Street Address _____City_____ Zip_____

REFERRING OPTOMETRIST: PLEASE PRINT CLEARLY

Name: Phone: Fax:

Address: City/Town: State: Illinois Zip:

Reason for Consultation: _____

_____

_____

_____

_____

_____

Dr. Reinglass, based on the above findings, I am requesting a consultation on behalf of this patient. I thank you in advance for a report of your medical assessment and recommendations. Please call my office if you have any questions.

Date: _____/_____/_____ Referring OD, Signature _____

PATIENT STATEMENT

The reason(s) for my referral to another doctor has been fully explained to me. I have had the opportunity to ask questions and I fully understand these reasons. I also understand that it is MY responsibility to follow-up the above named doctor, or a specialist of my choosing. I agree to give the above statement to the doctor I see in order for Dr. _____ to receive a report of the specialists findings.

Patient Signature: _____ Date: _____/_____/_____

Office: 1-773-465-3402 Fax: 1-773-761-9226

Lakeshoreeye.com eyesight@lakeshoreeye.com