PATIENT REFERRAL FORM

BEACH CITIES RETINA

Gautam Vangipuram, M.D.

555 Pier Ave, Suite D
Hermosa Beach, CA 90254

PHONE (310) 374-4848

FAX (310) 374-4850

EMAIL info@bcretina.com

Urgent (within 24 hours)

☐ Yes ☐ No

REFERRING INFO

Referring Doctor		Date
Phone:	Fax:	Email (optional)

PATIENT INFO

Please kindly remind patients a referral may be necessary from their primary physician depending on their insurance

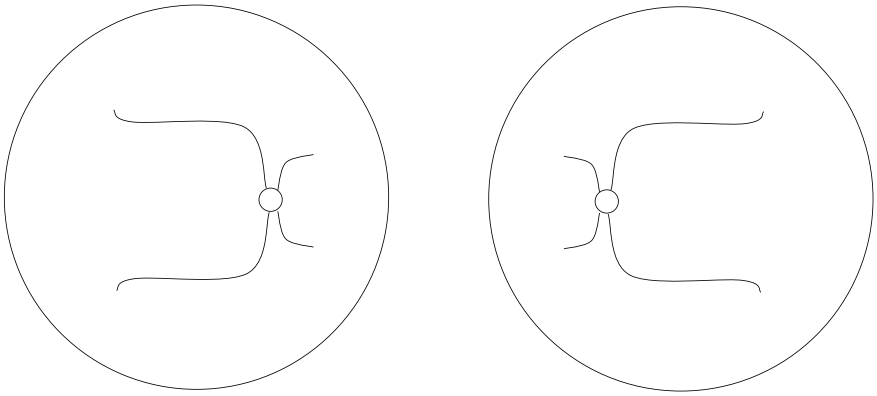
Patient Name	Phone	Date of Birth

Reason for Consultation/Treatment:

☐ Right Eye (OD) ☐ Left Eye (OS) ☐ Both Eyes (OU)

☐ Macular degeneration/AMD
☐ Macular Hole or Pucker
☐ Retinal Vein Occlusion
☐ Cystoid Macular Edema
☐ Diabetic Retinopathy
☐ Retinal Tear/PVD
☐ Retinal Detachment
☐ Retinal/Vitreous Hemorrhage
☐ IOL/lens issue
☐ Plaquenil Screening Ocular
☐ Nevus/Melanoma
☐ Other:_____

OD Area of concern & additional comments: OS



Specify if:

☐ Testing Requested:
☐ Ultrasound
☐ OCT
☐ Fundus Photography (WF)
☐ Fluorescein angiogram (WF)

PLEASE FAX FORM/RECORDS TO 310-374-4850 OR EMAIL INFO@BCRETINA.COM