RETINA CONSULTANTS

# ROUTINE REFERRAL FORM

To submit a routine referral, please fax this completed form to 701-205-3460 with the required information below:

- Patient demographics including patient name, DOB, address, phone number, medical insurance company, and medical insurance identification numbers.
- Referral office notes

Should any demographic, insurance, or diagnosis details be missing, we will contact you to obtain the necessary information before proceeding with scheduling for your patient. Please allow a minimum of four business days for our team to contact your patient to schedule an appointment.

For urgent referrals, please contact 701-293-9829, option 2 to speak with a clinical specialist who will assist with triage and immediate scheduling needs.

Date: ____________________________

Patient Name: ______________________________________________ Patient DOB: ________________________

☐ Patient demographics sheet attached with patient address, phone number, medical insurance company, and medical insurance identification numbers.

**REFERRAL INFORMATION:**

☐ Referral office notes attached. *Please note, office visit notes are preferred over a summary letter.

☐ Imaging has been sent to info@fargoretina.com

Referring Diagnosis/Reason: ______________________________________________________________________

Referring Provider: _________________________________________ Phone Number: ______________________

**PATIENT DEMOGRAPHICS:** *If a patient demographics sheet is attached, skip this section.

Address: ______________________________________ Phone Number(s): ____________________________

______________________________________ ____________________________

**INSURANCE INFORMATION:** *Please note, we only accept medical insurance. We do not accept vision insurance.

Please send a copy of the front and back of the patient's medical insurance card(s) with your referral.

Primary Medical Insurance

Carrier: ______________________________________

Insurance ID#: ________________________________

Policy Holder: ___________________________ ☐ Self

Policy Holder DOB: _____________________________

Secondary Medical Insurance

Carrier: ______________________________________

Insurance ID#: ________________________________

Policy Holder: ___________________________ ☐ Self

Policy Holder DOB: _____________________________

**FAX COMPLETED FORM WITH THE REQUIRED REFERRAL INFORMATION TO 701-205-3460**