Sugar Land Office
Ph: 281 545 4901
Fax: 281 533 6168

Webster Office
Ph: 281 338 1919
Fax: 281 299 0907

Downtown Office
Ph: 713 658 8301
Fax: 713 658 8300

Email: staff@evolutionaryeyecare.com
Website: www.EvolutionaryEyeCare.com

REFERRAL FORM

Date:___________ **Referring Doctor:**_____________________ **Office name/Phone**_______________

Patient Information:

Name: _______________________ D.O..B: ______________ Phone: _________________

Medical/Vision Insurance Information:

Primary Insured name: ______________________ D.O.B: _______________

Insurance name: __________________________ ID#:___________________

Reason for Referral:

- □ InfantSEE
- □ Low Vision Evaluation
- □ Vision Therapy Evaluation
- □ Keratoconus/Specialty Contact Lens Evaluation
- □ Myopia Control Evaluation
- □ Ocular Surface Disease (Dry Eye) Evaluation
- □ Diabetic Retinal Evaluation
- □ Emergency Red Eye/Foreign body removal
- □ Glaucoma Evaluation
- □ Other: (Please specify):____
- □ **Please refer patient back to our office for ongoing care**
- □ **Please keep patient at Evolutionary Eye Care for ongoing care**

Patient Medical Record Release to Evolutionary Eye Care

The request for your medical record release has been requested by EVOLUTIONARY EYE CARE

I authorize the release of my record to the above mentioned institution.

_______________________________.
(Patient Signature)