

PATIENT REFERRAL FORM



739 West Peachtree St. NW • Atlanta, GA 30308
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Accredited Member, National Accreditation Council United Way Agency

- ❶ Complete and fax this form to CVI at **404.875.4568**.
- ❷ Please include a copy of the patient's latest eye report *(if possible)*.
- ❸ CVI will contact your patient to schedule an appointment.

Patient Name: _____

Date of Birth: _____

Patient's Preferred Phone: _____

Address: _____

City/State/Zip: _____

Email: _____

Diagnosis: _____

Visual Acuities: Distance cc OD: _____ cc OS: _____

☐ Visual Fields Included *(if available)*

REFERRED BY:

Physician's name *(please print)*: _____

Physician Practice/Location: _____

Physician's Signature: _____

NPI: _____ Phone: _____

Address: _____

City/State/Zip: _____

Referral Date: _____ Date of Office Visit: _____

RECOMMENDED LOCATION FOR LOW VISION EVALUATION: *(please mark one)*

- | | |
|--|--|
| ☐ CVI Main Clinic, Atlanta | ☐ New Rock Day Treatment Ctr., Covington |
| ☐ Hope Haven of Northeast GA, Athens | ☐ Eye Physicians & Surgeons, Decatur |
| ☐ Georgia Retina, Braselton | ☐ Avita Community Partners, Flowery Branch |
| ☐ Eye Consultants of Atlanta, Cumberland | ☐ North Georgia Eye, Gainesville |
| | ☐ ViewPoint Health (Crews Ctr.), Lawrenceville |