HIGH POINT UNIVERSITY
EYE HEALTH

Request for Referral

HPU Eye Health
Phone: 336-841-2970 | www.hpueyehealth.com

Please send the completed form and most recent exam data to: hpeyeinstitute@highpoint.edu

Date of Referral: _____

Patient Information

Patient Name: _____ **DOB:** _____

Phone #1: _____ **Phone #2:** _____

Address: _____ **City/State:** _____ **ZIP Code:** _____

Patient Insurance: _____ Is this HMO? ☐ No ☐ Yes

Referral Information

Referring patient for: (check all that apply)

- ☐ Glaucoma
- ☐ Retina and Diabetes Eye
- ☐ Specialty Contact Lens
- ☐ Dry Eye
- ☐ Myopia Management
- ☐ Refractive Surgery Consult
- ☐ Low Vision Rehabilitation
- ☐ Pediatrics
- ☐ Binocular Vision
- ☐ Special Populations
- ☐ Neuro-Optometry
- ☐ Traumatic Brain Injury
- ☐ Other (explain below)
- ☐
- ☐

Diagnostic Testing

Requested testing: (check all that apply)

- ☐ OCT of anterior chamber angle
- ☐ OCT of ONH
- ☐ OCT of macula
- ☐ OCT with Angioplex
- ☐ Fundus Photos
- ☐ Meibography
- ☐ Topography/Tomography
- ☐ A-Scan/IOL Master
- ☐ B-Scan
- ☐ Pachymetry
- ☐ Visual Field Testing
- ☐ Endothelial Cell Count

Completing this form helps our consulting clinicians provide timely correspondence. Please print clearly.

Provider First and Last Name: _____

Practice Phone: _____ **Practice Records Fax:** _____

Practice Address: _____

City: _____ **State:** _____ **9-Digit ZIP Code:** _____

Provider NPI #: _____

Provider Email: _____

☐ Please call my patient to schedule ☐ My patient will call to schedule ☐ Appointment made:

Additional Comments