METROLINA EYE ASSOCIATES
A CLEAR VISION OF EXCELLENCE

PROVIDER REFERRAL FORM

Date_____

REFERRAL PRIORITY REQUEST

- ☐ EMERGENCY - Call (704) 774-1165
- ☐ Urgent - Within 7 Days
- ☐ Next Available Appointment

LOCATION REQUESTED

- ☐ Matthews ☐ Monroe ☐ Randolph Rd. ☐ University
- ☐ Indian Land ☐ Rock Hill ☐ Pineville

Preferred Physician (optional): _____

Referring Provider Information (Required)

Name:_____ NPI_____

Practice Name:_____

Address: _____

Phone: _____ Direct Fax: _____

Patient Information (Required) ☐ ATTACH DEMOGRAPHIC SHEET →

Attach only if all requested patient information has been provided.

Patient Name:_____ DOB:_____

Patient Address: _____

Phone #1: _____ Phone #2:_____

Insurance: _____ Policy Number: _____

Preferred Language: _____ ☐ Needs Translator Gender: ☐ Male ☐ Female

REASON

- ☐ ARMD - Dry Only
- ☐ Blepharitis
- ☐ Cataracts
  - ☐ Patient will not be co-managed
- ☐ Cornea Transplant
- ☐ Corneal Abrasion
- ☐ Corneal Disease
- ☐ CSR
- ☐ Diabetic Eye Exam
- ☐ Diplopia
- ☐ Eye Exam/Glasses/Contacts
- ☐ Eyelid Lesion
- ☐ Eyelid Lesion/Hordeolum
- ☐ Eyelid Malposition
- ☐ Facial Spasms
- ☐ Failed Vision Screening
- ☐ Floaters
- ☐ Foreign Body
- ☐ Fuchs' Dystrophy
- ☐ Glaucoma
- ☐ Graves' Disease
- ☐ Headaches/Migraine
- ☐ Keratoconus
- ☐ LASIK/PRK/ICL
- ☐ Mohs Repair
- ☐ Nasolacrimal Duct
- ☐ Ocular Irritations
- ☐ Open Globe Repair
- ☐ Plaquenil Screening
- ☐ Ptosis/Dermatochalasis
- ☐ Refractive Lens Exchange
- ☐ RLE Consultation
- ☐ Surface Disease
- ☐ Tearing
- ☐ Thyroid Eye Disease
- ☐ Uveitis
- ☐ Valeda
- ☐ Yag Evaluation

Additional Comments: _____

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Our goal is to contact patients within 24 hours. Please note, Medicaid eligibility verification may take up to 72 hours. To help prevent scheduling delays, **please ensure all referral information is accurate and include visit note(s) relevant to this referral.**

FAX COMPLETED FORM TO 704-635-7784. For additional support or questions about your referral, please call us at 704-774-1165 or email referrals@metrolinaeye.com