

Urgent

**Required*

*Date _____ *PRACTICE NAME _____
 *Referring Physician _____ *NPI _____
 *Phone _____ Fax _____
 *Address _____ Email _____

*Patient Name _____ DOB _____
 Address _____
 City _____ Zip _____
 *Phone _____ *Cell Phone _____
 Email _____
 *Insurance _____ *Policy Number _____
 Gender: Male Female *Requested MEA Physician _____

Reason

- | | | |
|---|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Headache/Migraine | <input type="checkbox"/> Corneal Transplant |
| <input type="checkbox"/> Patient will not be co-managed | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Vein Occlusion |
| <input type="checkbox"/> LASIK/PRK/ICL | <input type="checkbox"/> Ptosis/Dermatochalasis | <input type="checkbox"/> Artery Occlusion |
| <input type="checkbox"/> Eyelid Lesion | <input type="checkbox"/> Tearing | <input type="checkbox"/> ARMD |
| <input type="checkbox"/> Eyelid Malposition | <input type="checkbox"/> Facial Spasms | <input type="checkbox"/> Macular Hole |
| <input type="checkbox"/> Thyroid Eye Disease | <input type="checkbox"/> Nasolacrimal Duct | <input type="checkbox"/> Macular Adema |
| <input type="checkbox"/> Graves Disease | <input type="checkbox"/> Diplopia | <input type="checkbox"/> Diabetic Retinopathy |
| <input type="checkbox"/> Mohs Repair | <input type="checkbox"/> Failed Vision Screening | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Eyelid Lesion/Hordeolum | <input type="checkbox"/> Eye Exam/Glasses/Contacts | <input type="checkbox"/> Epiretinal Membrane |
| <input type="checkbox"/> Blepharitis | <input type="checkbox"/> Ocular Irritations | <input type="checkbox"/> Corneal Abrasion |
| <input type="checkbox"/> Foreign Body | <input type="checkbox"/> CSR | <input type="checkbox"/> Corneal Disease |
| <input type="checkbox"/> Diabetic Eye Exam | <input type="checkbox"/> Uveitis | <input type="checkbox"/> Open Globe Repair |
| <input type="checkbox"/> Plaquenil Screening | <input type="checkbox"/> Toxoplasmosis | <input type="checkbox"/> Cross-Linking |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Histoplasmosis | <input type="checkbox"/> Intacs |
| <input type="checkbox"/> Other/Notes _____ | | |

Our goal is to contact patients within 24 hours. Please be advised, Medicaid can take up to 72 hours to process for eligibility. FOR QUESTIONS/ISSUES ABOUT YOUR REFERRAL, PLEASE CALL 704-774-1165 or email referrals@metrolinaeye.com

Fax/Email Referral Requests to 704-635-7784 or referrals@metrolinaeye.com

www.metrolinaeye.com

UPTOWN, UNIVERSITY, MATTHEWS, MONROE, ROCK HILL & INDIAN LAND