METROLINA EYE ASSOCIATES
A Clear Vision of Excellence

REFERRAL FORM

☐ **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

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

☐ 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