Patient Referral Request Form

SIFRI Eye Center

Alexander Kuley, M.D.
Greg Sanda, M.D.
513-922-1550 / 513-922-1572 (fax)

Location Preference
Harrison
Western Hills

Urgency: call office for same or next day appointments.
Otherwise:
Next available
Within 1 week
Within 1 month

Referring Dr. / Practice: *boxes editable/clickable*_____

Patient name:_____

Patient phone #:_____

Date of Birth:_____

Medical Insurance (required):_____

Please include a copy of the **medical insurance** card if possible.

Patient consultation requested for:

Cataract evaluation	Retinal tear / detachment	PVD
Glaucoma evaluation	Macular degeneration. Wet / dry	Vitreous hemorrhage
Tearing	Diabetes: NPDR	Uveitis / Iritis
Secondary cataract	Diabetes: PDR	CRAO
Corneal evaluation	Macular edema	Papilledema
Chalazion	BRVO / CRVO	Lattice / myopia / holes
CSR	Retinal dystrophy	VMT
Nevus	other: _____	

Referring to: **Alexander Kuley, M.D. (retina and cataract)**

Greg Sanda, M.D. (cataract, MIGS, comprehensive)

No doctor preference

Notes for the Doctor:

_____

_____

Best corrected visual acuity: OD _____ OS _____

Referring Doctor's signature: _____

Fax: 513-922-1572
Email: info@sifrieyecenter.com
2745 Anderson Ferry Rd. Cincinnati, Ohio 45238
1100 Harrison Ave. Harrison, Ohio 45030
513-922-1550