RETINA OF ILLINOIS, S.C.

Aashish V. Gandhi, M.D., FACS

PATIENT REFERRAL TO RETINA OF ILLINOIS, S.C.

We value your trust and are committed to providing outstanding retinal care to our mutual patient. In order for us to get all necessary information and make sure we accept the patient's insurance, **we ask you to complete this referral form and fax it to us along with the exam notes and medical insurance cards.**

Patient Demographic Information:

Name:_____ DOB:_____

Address:_____City_____State____Zip_____

Tel#:_____

Insurance: Primary_____ Policy #_____

Secondary_____ Policy #_____

Referral Information:

Referring Physician:_____ Exam Date:_____

Vision Right Eye:_____ Vision Left Eye:_____

Ocular History:_____

Ocular Findings:_____

Requesting (please circle):

- Retinal Consultation and Treatment
- Ocular Coherence Tomography
- Other:_____

******Along with this referral form please fax us the following:******

•Exam Notes **•Medical Insurance Cards**

Champaign Office
2902 Crossing Ct., Suite E
Champaign, IL 61822
P: 217-355-7494
F: 217-355-7495

Bourbonnais Office
475 Brown Blvd., Suite 109
Bourbonnais, IL 60914
P: 815-802-2090
F: 815-802-2093