Grube Retina Clinic, P.C.
Thomas J. Grube, M.D.

RETINA REFERRAL FORM

Date

Referring Doctor

Office Address

City State Zip

Phone

Fax

Patient Name D.O.B.

Address

City State Zip

Phone(Home) (Cell)

Insurance/Policy #

****Please provide chart notes and any other information pertaining to patients continued care.**

DIAGNOSIS: ☐ **OD** ☐ **OS** ☐ **OU**

☐ Macular Degeneration
☐ Diabetic Retinopathy
☐ Retinal Detachment
☐ Retinal Tear
☐ Macular Hole
☐ EpiRetinal Membrane
☐ Vein Occlusion
☐ Choroidal Nevus
☐ Other ______________________________

VA: OD______________ OS______________

IOP: OD______________ OS______________

NOTES:

**** REMINDERS FOR PATIENTS WHEN VISITING OUR OFFICE:**
Plan on being in our office at least 2 hours
Both Eyes will be Dilated
Arrange to have a Driver
Bring a list of Medications
Bring all Insurance Cards

Thank you for referring your patient to our clinic.

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