



William J. Carroll, MD
peachstateretina.com
Fax: (478) 500-8205

Date of Referral: _____

Retina Referral Form

Peach State Retina

Please fax this completed form and all relevant clinical notes and imaging to **(478) 500-8205**.
If this is an emergency, please call our office directly.

Loganville	Milledgeville	Eastman
3535 Highway 81 Loganville, GA 30052 Phone: (770) 520-8303	100 E Greene St. 2 nd Floor Milledgeville, GA 31061 Phone: (478) 223-9001	750 Medical Center Dr. Eastman, GA 31023 Phone: (478) 500-8022

Referring Doctor Information

Referring Doctor Name: _____

Practice Name: _____

Phone Number: _____ Fax Number: _____

Preferred Contact Method: Phone Fax

Patient Information

Full Name: _____

Phone Number: _____ Date of Birth: _____

Insurance: _____

Requested Appointment Timeframe

- | | |
|--|---|
| <input type="checkbox"/> Within 24 Hours (please send notes) | <input type="checkbox"/> Within 2-4 Weeks |
| <input type="checkbox"/> Within 24-72 Hours | <input type="checkbox"/> Next Available |
| <input type="checkbox"/> Within 1 Week | <input type="checkbox"/> Other: _____ |

Reason for Referral

- | | |
|---|---|
| <input type="checkbox"/> Macular Degeneration (Dry/Wet) | <input type="checkbox"/> Retinal Artery Occlusion |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Epiretinal Membrane | <input type="checkbox"/> Retinal Tear |
| <input type="checkbox"/> Flashes/Floaters | <input type="checkbox"/> Retinal Vein Occlusion |
| <input type="checkbox"/> Macular Hole | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Post-Operative Concern | |