NRV EYE CENTER PATIENT REFERRAL FORM
Tedd R. Puckett, MD, FACS

Please complete requested information below in order to expedite the referral process.
We will verify insurance first and then call patient to schedule in 3-4 days.

Physician requesting consult: _____ Fax # _____

Office Contact Person: _____ Phone # _____

Reason for consult: ☐ Cataract - Ready for Surgery ☐ Cataract Evaluation Only
☐ YAG Capsulotomy ☐ Glaucoma Laser SLT/ALT ☐ YAG Laser Iridotomy
☐ Diabetic Eye Exam ☐ DME ☐ PDR ☐ Other (specify): _____

☐ RIGHT EYE ☐ LEFT EYE Wears contact lenses: ☐ YES ☐ NO

☐ Ambulatory ☐ Walker/Cane/Wheel Chair ☐ Medical Power Of Attorney ☐ Oxygen
☐ Other Restrictions (specify)**:** _____

DOES PATIENT HAVE ANY OF THE FOLLOWING?
☐ Diabetic Retinopathy ☐ Macular Degeneration ☐ Glaucoma ☐ Diabetes

Patient Name (How it is on PRIMARY insurance card): _____

M ☐ F ☐ DOB: _____ PHONE: (____)_____ ALT # (____) _____

Mailing Address _____

Primary Insurance: _____ ID# _____ Group #_____

Secondary Ins. :_____ ID# _____ Group #_____

Pharmacy: _____

Please inform patients our Wytheville office is for cataract or laser related appointments only.

PLEASE FAX COMPLETED FORM AND ATTACHMENTS TO (540) 382-8980.

- Insurance Cards (FRONT AND BACK)
- Office note(s), Last exam, imaging/diagnostic reports if applicable.
- Co-Managed Share Care Agreement (needed only for Cataract Surgery).

WE WILL VERIFY INSURANCE FIRST AND THEN CALL PATIENT TO SCHEDULE IN 3-4 DAYS.
IF ANY QUESTIONS, PLEASE CALL (540) 381-2013
Thank you for the opportunity to serve your patient.

REFERRAL FOR CATARACT SURGERY/POST-OPERATIVE AGREEMENT

The results of today's examination have concluded that you have a cataract, a clouding of the natural lens of the eye. The cataract has progressed to a point that a change in your eyeglass prescription will not restore your vision to a normal and reasonable level. I am therefore recommending a referral for cataract surgery.

My staff will schedule a surgical consultation with an ophthalmic surgeon of your choice. All questions regarding your selection of a surgeon will be answered completely and additional written information regarding the specific training of your surgeon will be provided upon your request. The surgery is generally performed at an out-patient surgery center. Upon mutual agreement between you and the surgeon, the surgeon may release you back to this office for the completion of your post-operative care when it is clinically appropriate to do so.

Recommended Ophthalmic Surgeon: Tedd R. Puckett, M.D. F.A.C.S./ NRV Eye Center

(Offices: 106 S. Franklin St. Phone, Christiansburg, and 310 East Main Street, Wytheville) Phone 540-381-2013 Fax 540-382-8980 www.NRVeye.com

Date of Initial Evaluation: _____ Office: ___ C'burg ___Wytheville

Tentative date for surgery: _____

1 or 2 day post-op visit with Dr. Puckett: _____

One week post-op visit with Dr. _____

PATIENT NAME: _____

PATIENT SIGNATURE: _____

OPERATIVE EYE: (please circle one) RIGHT / LEFT

REFERRING DOCTOR: _____

REFERRING DOCTOR'S SIGNATURE: _____

DATE: _____

You can email this completed form to: reception@nrveye.com