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.

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