Columbus Ophthalmology Associates

PATIENT REFERRAL FORM

FAX: 614-766-4637

Patient Name: _____ **Patient Phone #**: _____

MD Requested:

□ Richard G. Orlando, M.D., F.A.C.S.
□ Robert J. Derick, M.D.
□ Charles J. Hickey, M.D., F.A.C.S.
□ James A. McHale, M.D.
□ Thomas C. Litzinger, M.D.
□ Michael S. Bloom, M.D.

Reason for Referral:

☐Cataract Evaluation
☐Corneal Evaluation
☐Diabetic Evaluation
☐Glaucoma Evaluation
☐Lid Lesion / Ectropion / Entropion
☐Muscle Evaluation / Diplopia
☐Retinal Evaluation
☐Refractive Surgery Evaluation
☐Tearing / Nasolacrimal Duct Obstruction
☐Other _____

Manifest Refraction: **OD** _____20/_____ **OS** _____20/_____

Time frame to be seen within: _____ Days _____ Weeks _____ Months

Diagnosis: _____

Referring OD / MD: _____

Fax # where you would like confirmation of the appointment sent: _____

For COA Office Use Only

Appointment Date: _____ **Time**: _____ AM PM

Office Location: Dublin East GC WCH

Attempts to Contact Patient:

_____

Form Faxed to Referral Source as Confirmation of Appointment:

Date: _____ Fax Confirmation Received: YES Scheduler Initials: _____