CASCADE RETINA

Please fax to: 425-533-9800

10521 19th Ave SE Suite 100
Everett, WA 98208
Phone: 425-533-9777

Patient Referral Form

Patient Information

Name: _____ DOB: _____

Address: _____ Ph #: _____

City State Zip: _____ Email: _____

	PRIMARY	SUPPLEMENTAL/SECONDARY
Insurance Plan:	_____	_____
Member ID:	_____	_____
Group #:	_____	_____

Reason for Referral

_____

_____

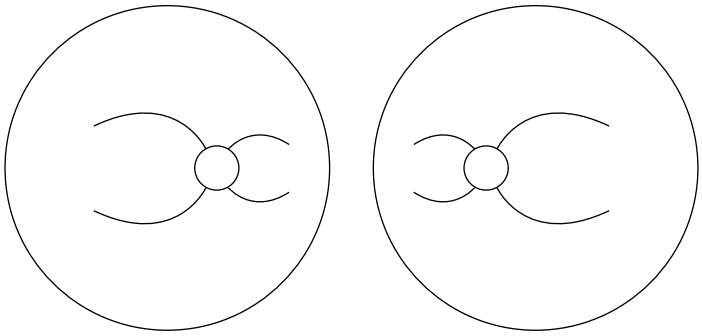
_____

When do you want the patient to be seen?

☐ Immediately ☐ Within one week

☐ Within one month ☐ Patient preference

☐ Other:



OD **OS**

Please call the office for urgent referrals

Referring Doctor

Name: _____ Practice Name: _____

Office Address: _____

Phone #: _____ Fax #: _____