DURRIE VISION

PATIENT REFERRAL FORM

Referring Doctor: *Please fax completed form to (913) 491-9650 or scan and email to dvrcc@durrievision.com.*

☐ Check here if the patient would like Durrie Vision to call to schedule an appointment.

Referring Doctor

Name: _____ Practice Name: _____

Address: _____

Phone: _____ Fax: _____

HIPAA Compliant email: _____

Patient Information

Patient Name: _____ Phone: _____

Date of Birth: _____ Exam Date: _____

Reason for Referral

☐ Surgical consultation

☐ Continued care

Examination Data:

Refraction:

OD: _____ _____ x ____

OS: _____ _____ x ____

BCVA:

OD: ___ / 20 OS: ___ / 20

History/Comments: _____

_____