SOUTHEASTERN RETINA SPECIALISTS®

Fax Appointment Request

Date: **Referred To:** ☐ Dr. Agee ☐ Dr. Sullivan ☐ 1st Available

SRS Office Fax: 904-527-3514 **Patient Name:**

SRS Office Phone: 904-527-3577 **Patient DOB:**

Referring Physician: **Patient Phone #:**

REASON FOR VISIT (PLEASE CHECK ALL THAT APPLY)

- ☐ Branch Retinal Artery Occlusion
- ☐ Branch Retinal Vein Occlusion
- ☐ Central Retinal Artery Occlusion
- ☐ Central Retinal Vein Occlusion
- ☐ Central Serous Retinopathy
- ☐ Choroidal Nevus
- ☐ Cystoid Macular Edema
- ☐ Diabetic Exam (no problems)
- ☐ Diabetic Maculopathy
- ☐ Endophthalmitis
- ☐ Epi-Retinal / Epi-Macular Membrane
- ☐ Flashes / Floaters
- ☐ Histoplasmosis
- ☐ Lattice Degeneration
- ☐ Macular Degeneration
- ☐ Macular Hole / Macular Pucker
- ☐ Malignant Melanoma
- ☐ Neovascular Glaucoma
- ☐ PVD (w/flashes / floaters)
- ☐ Papilledema
- ☐ Retained Intraocular Foreign Body
- ☐ Retained Lens / Dislocated IOL
- ☐ Retinal Detachment
- ☐ Retinal Tear
- ☐ Surgery Clearance
- ☐ Trauma / Open Globe
- ☐ Uveitis
- ☐ Vitreous Hemorrhage (Diabetic)
- ☐ Vitreous Hemorrhage (Non-Diabetic)
- ☐ Other _____

PATIENT SPECIAL NEEDS - ☐ **public transportation** ☐ **care giver assistance** ☐ **language/translator**

***Please include with this fax the patient's demographics with insurance information, treatment records and test results (OCT & Fundus Photos, if done) related to the reason for referral.**

CONFIDENTIAL

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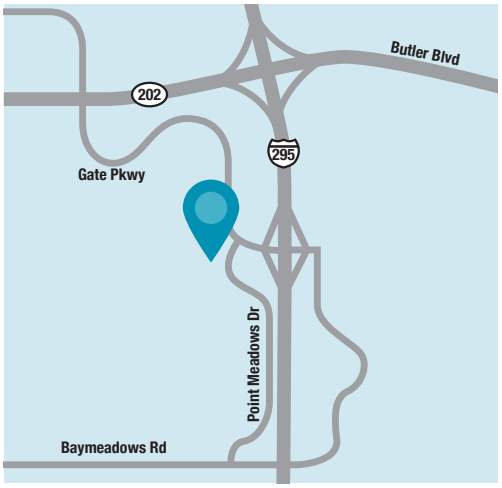
SOUTHEASTERN RETINA SPECIALISTS®

Patient Name:

Appointment Date: **Time:**

☐ *Jacksonville*

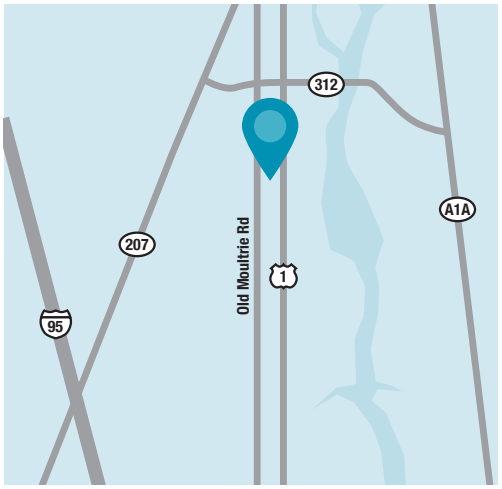


7740 Point Meadows Drive
Suite 3A
Jacksonville, FL 32256
904-527-3577 PHONE
904-527-3514 FAX

☐ *Palatka*

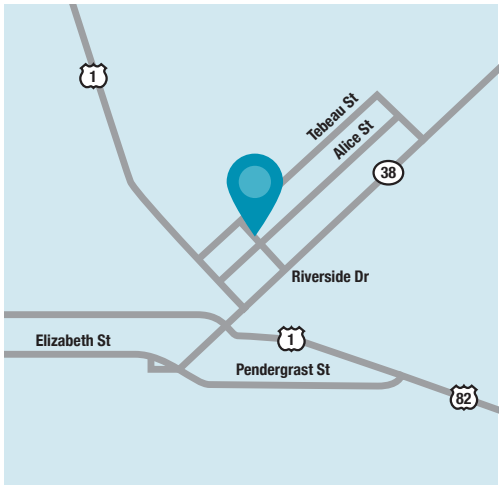
800 Zeagler Drive
Suite 400
Palatka, FL 32177
386-530-6850 PHONE
386-530-2109 FAX

☐ *St. Augustine*



2155 Old Moultrie Rd
Suite 105
St. Augustine, FL 32086
904-342-3675 PHONE
904-342-7193 FAX

☐ *Waycross, GA*



406 Riverside Drive
Waycross, GA 31501
912-387-0020 PHONE
912-338-8955 FAX