Robert L. Lesser, MD
Stanley B. Hersh, MD
Andrew J. Levada, MD
Craig A. Sklar, MD
Aron D. Rose, MD
Peter J. Branden, MD
Stephanie L. Sugin, MD
Yanina Kostina, MD
Joel A. Geffin, MD
Jonathan E. Silbert, MD

The Eye Care Group

Excellence and Compassion in Eye Care

Cinthia G. Covey, MD
Tara H. Cronin, MD
Danielle S. Rudich, MD
Steven C. Thornquist, MD
Thomas L. Berenberg, MD
Joan P. Draper, MD
Nhu-Y Dao, MD
Erika N. Wandel, MD
Alexander Nguyen, MD

REFERRAL FORM

Date: _____ / _____ / _____

First Name: _____

Last Name: _____

Date of Birth: _____ / _____ / _____

Please attach Patient's Demographic Sheet to include:

☑ Address ☑ Contact Number

☑ Primary/Secondary Insurance Information

☑ Primary Care Physician _____
(If other than Referring MD)

Referring Physician/Provider :

_____

MD / DO / OD / APRN / PA (circle one)

Provider NPI#: _____

Practice Name: _____

Street Address: _____

City: _____

State : _____ Zip Code: _____

Practice Telephone Number: _____

Practice Fax Number: _____

Signature of Referring Provider:

_____

Does patient reside in a Skilled Nursing Facility (SNF)?

☐ Yes ☐ No If yes...

Skilled Nursing Facility: _____

Address: _____

City: _____

State/Zip: _____

Phone Number: _____

Accommodations Needed:

Language Interpreter Needed: ☐ Yes ☐ No

Specify Language: _____

Hearing Impaired: ☐ Sign Language

☐ Other _____

Handicapped: ☐ Wheelchair

☐ Other _____

Type of Care Requested:

☐ Consultation Only ☐ Consultation and Treatment

Reason for Treatment:

_____

_____

Please include any clinical documents pertinent to the patient's visit.

Referral To:

☐ Robert L. Lesser, MD	☐ Peter J. Branden, MD	☐ Cinthia G. Covey, MD	☐ Joan P. Draper, MD
☐ Stanley B. Hersh, MD	☐ Stephanie L. Sugin, MD	☐ Tara H. Cronin, MD	☐ Nhu-Y Dao, MD
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☐ Aron D. Rose, MD	☐ Jonathan E. Silbert, MD	☐ Thomas L. Berenberg, MD	

Please fax completed Referral Form and pertinent documents to 203-805-0805.

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Waterbury, CT 06708

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