Cascade Eye Care

1751 Hartnell Ave Ste.1
Redding, CA 96002

Phone: (530) 223-2325
Fax: (530) 223-2252

Prior Referral Request Form

To PCP/Facility: _____ Phone#:_____

Address: _____ Fax#: _____

Patient Name: _____ Patient DOB: _____

Anticipated Appt. Date: _____ with Dr. _____

The above patient carries an insurance that may need a prior referral or authorization as they may be enrolled in a managed care plan. The necessary referral or authorization is needed before our ophthalmologist is able to see them for this visit.

Along with a complete annual eye exam and refractive error checks, our ophthalmology services may also include various eye testing and examination services when patient may show such indications of:

Diabetic Retinopathy	Strabismus	Pterygium
Retinopathy of Prematurity	Dermatochalasis	Herpetic Eye Infection
Cataracts	Eye Pain	Retinal Detachment
Glaucoma	Corneal Scar or Ulcer	Age Related Macular Degeneration
Amblyopia	Foreign Body in Cornea	
Nystagmus	Dry Eye Syndrome	

Examples of possible additional testing may include:

- Dilated Fundus Exam
- External Photography
- Topography
- Fundus Photography
- Ocular coherence Tomography (OCT)
- Ultrasonography A-Scan/ B-Scan
- Visual Field Examination
- Sensorimotor Exam

_____ _____

Referring Physician Signature Referring Physician NPI #