

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 #

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