FURLONG
VISION CORRECTION
An NVISION® Eye Center

Medical Eye Referral Form

fax to 855-598-6850

Patient Information

Date:			
Last Name	First Name	MI	DOB
Address	City	State	Zip Code
Daytime Phone & Area Code	Cell Phone & Area Code	Email	

Medical Insurance Information:

- ☐ Aetna PPO
- ☐ Anthem PPO
- ☐ Blue Shield PPO
- ☐ Cigna PPO
- ☐ Humana PPO
- ☐ Medicare
- ☐ United Health Care PPO
- ☐ None (Cash Pay)

PLEASE NOTE we do not accept any HMO or EPO plans

Please fax a copy of the patient's medical insurance card if available

Reason for Referral

☐ Cataract

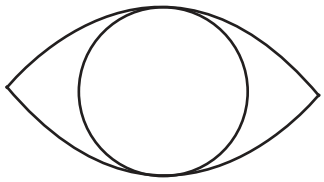
For cataract co-management, please mark one box:

- ☐ I agree to provide post-op care based on the patient's medical insurance or intraocular lens choice.
- ☐ I prefer Furlong Vision Correction provide post-op care and refer the patient back once healing is complete.

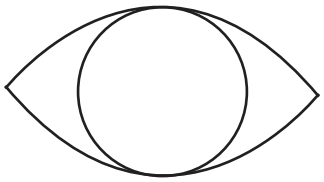
☐ Cornea

☐ Keratoconus

☐ Pterygium



OD



OS

Provisional Diagnosis	BCVA OD: 20/	OS: 20/
Additional Information		

Optometrist Information

Referring Optometrist Name	Practice Name
Practice Phone	