



RETINA

EYE SPECIALISTS

POOJA GARG, MD

Vitreo-Retinal Specialist

REFERRAL FORM

DIRECTIONS: Please fax to 954-586-4196 or Give to the patient to
bring to the appointment

Referring Doctor: _____ Appt Date: _____

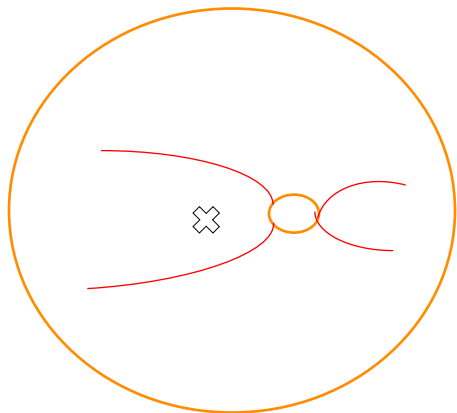
Patient Name: _____ Age _____ DOB: _____

Patient Number: _____

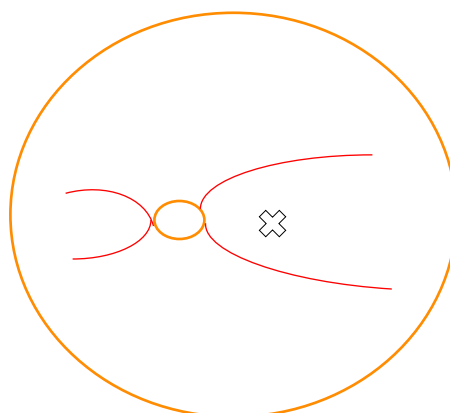
Reason for Consult: OD OS OU

- | | |
|--|--|
| ☐ Diabetic Retinopathy | ☐ Central / Branch Retinal Vein Occlusion |
| ☐ Macular Degeneration | ☐ Dislocated Lens |
| ☐ Macular edema / hole / membrane | ☐ Maculopathy |
| ☐ Flashes and Floaters | ☐ Choroidal Nevus / Melanoma / Mass |
| ☐ Retinal Tear / Hole / Lattice | ☐ Uveitis |
| ☐ Retinal Detachment | ☐ Unexplained Visual Loss |
| ☐ Other: (please specify) _____ | |

OD



OS



Comments: _____

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