DAVID SWITZER, MD
Vitreoretinal Surgeon

R&M BILLINGS RETINA & MACULA

QUESTIONS? CALL 406-252-5681

REFERRAL FORM

PATIENT INFO:

Patient Name ________________________ **DOB** ___________ **Phone** __________________

Urgency of Referral ☐ *48 Hrs* ☐ *< 1 week* ☐ *Pt Preference*

* If this is a medical emergency, do not fill out this form, instead call our *24/7* service at 406-252-5681

REFERRING PROVIDER INFO:

Provider Name ______________________________

Phone ______________________

Fax _________________________

Practice Name ____________________________

Practice Location __________________________

***Eye Involved** ☐ *RIGHT EYE* ☐ *LEFT EYE* ☐ *BOTH EYES*

Reason For Consultation:

<u>IMPORTANT:</u> FAX following files to (406) 252-5025 --OR-- EMAIL available upon request

☐ ***Patient Demographics*** ☐ ***Copy of Insurance Cards*** ☐ ***Recent Exam Notes*** ☐ ***OCT / Pictures***