PHYSICIAN REFERRAL FORM

TO: InSight Vision Center **FAX TO:** (559) 432-2632 **EMAIL TO:** referrals@insightvisioncenter.com

DATE: _____ **TIME:** _____ AM/PM **NUMBER OF PAGES:** _____

Physician:

☐ Eric J. Poulsen, MD ☐ Azhar I. Salahuddin, MD ☐ W. Andrew Maxwell, MD, PhD

☐ Ashley M. Riley, MD ☐ Sanket S. Shah, MD ☐ Sharon S. Hiyama, OD

☐ Patrick J. Scott, OD ☐ Lisa L. Lu, OD

Requesting Physician Responsibility

Please complete and fax this form for referral appointments. Your patient will be contacted by an InSight Vision Center staff member to schedule the appropriate appointment. The response portion listed below will be filled out and faxed back within 24-48 hours.

URGENT SAME-DAY APPOINTMENTS *can be scheduled by calling* ***(559)207-6004*** *(direct) or* ***(559)449-5050*** *(main).*

Patient Information: (please attach necessary notes, etc.)

Name		Age
Address		
City	State	Zip
Main Phone	Alt Phone	
DOB	Male ☐	Female ☐
Insurance	ID#	

Requesting Physician Information:

Name		
Clinic Name / Specialty		
Address		
City	State	Zip
Phone	Fax	
NPI #		

Requesting physician is responsible for *prior authorization.*

REFERRAL INFORMATION *(to be completed by the requesting physician)*:

1. Referred for: ☐ **Cataract** ☐ **Diabetes** ☐ **Glaucoma** ☐ **Retinal** ☐ **Refractive Error**

☐ **Free LASIK Consultation** ☐ **Other:** _____

2. Parent or Guardian's name (if patient is under 18): _____

- PLEASE DO NOT WRITE BELOW THIS LINE -

TO: _____ **FAX TO:** (___) _____ **NUMBER OF PAGES:** _____

FROM: InSight Vision Center **DATE:** _____ **TIME:** _____ AM/PM

Scheduled for Examination: Date: ____ /____ /_____ Time: _____ AM/PM

Your patient is scheduled to be seen by: ☐ Dr. Poulsen ☐ Dr. Salahuddin ☐ Dr. Maxwell ☐ Dr. Riley ☐ Dr. Shah ☐ Dr. Hiyama ☐ Dr. Scott ☐ Dr. Lu

Main Office Location: ☐
1360 East Herndon Ave. #201
Fresno, CA 93720

2nd Location: ☐
1360 East Herndon Ave. #103
Fresno, CA 93720

Chestnut Location: ☐
7015 N. Chestnut Ave, #101
Fresno, CA 93720