Friedrich Eye Associates, PLLC

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Phone: (423) 702-2020 Fax: (423) 702-2021

REFERRAL FORM

DATE: _____

REFERRING PHYSICIAN'S NAME: _____

REFERRING PHYSICIAN'S PHONE: _____ FAX: _____

PATIENT'S NAME: _____ DOB: _____

PHONE NUMBER: _____ ADDITIONAL NUMBER: _____

REFERRAL TO:

_____ DAVID L. FRIEDRICH, MD
_____ AARON G. THOMPSON, OD
_____ FIRST AVAILABLE

REASON FOR REFERRAL:

_____ CATARACT EVALUATION
_____ DIABETES SCREENING/ EYE EXAM
_____ ROUTINE DILATED EYE EXAM
_____ GLAUCOMA
_____ REDNESS IN EYE OR AROUND EYES
_____ FOREIGN BODY IN EYE
_____ DRY EYES
_____ EYE LESION
_____ FLASHES/FLOATERS
_____ IRITIS/INFLAMATION
_____ MACULAR DEGEN.
_____ STYE/CHALAZION
_____ OTHER: _____

Inner office use:
Appointment Date: _____ Time: _____ am pm with ____Dr. Friedrich____ Dr. Thompson
Patient Notified via Phone Letter E-mail
Appointment Scheduled by FEA Employee: _____

Thank you for trusting us in the care of your patient's vision and eye needs!