THIRDCOAST RETINA

262-420-5888 (fax: 262-420-5889)
5017 Green Bay Rd. Suite 148 Kenosha, WI 53144
www.tcrmd.com
@thirdcoastretina

Referral Form

Please fax the completed form to 262-420-5889, we will call and schedule the appointment.
If this is for a dislocated IOL, please send the referral with an IOL Master.

Patient Information

Name: _____ **DOB**: _____

Address: _____ **Phone** #: _____

City, State, Zip: _____ **Email**: _____

Primary Insurance: _____ **Member ID**: _____

Secondary Insurance: _____ **Member ID**: _____

Reason for Referral: _____

How soon would you like the patient to be seen?

⬜ Immediately ⬜ Within one week ⬜ Other: _____

⬜ Within one month ⬜ Patient Preference

Please call the office for urgent referrals

Referring Provider and Practice: _____

Address: _____ **City, State. Zip**: _____

Phone #: _____ **Fax #**: _____

Please send the patient's last visit note as this will save them time during their visit with us.
Thank you!