Wallerich
EYE CARE

❑ **Wallerich Eye Care – St. Paul (Midway)**
1300 University Ave W
Saint Paul, MN 55104
T: (612) 643-3525
F: (612) 299-1452
Email: OM@WallerichEyeCare.com

❑ **Wallerich Eye Care – Eden Prairie**
8225 Flying Cloud Drive
Eden Prairie, MN 55344
T: (612) 643-3525
F: (612) 299-1452
Email: OM@WallerichEyeCare.com

REFERRAL FORM (*Select Preferred Location Above*)

Date

Referred By (Provider Name)

Practice Name/Location

Phone Fax

Email Address

Patient's Name Date of Birth

Contact Information: Parent/Guardian

Address City State Zip

Phone Email Address

REASON(S) FOR REFERRAL
Check all that apply

❑ **MEDICAL EYE CARE**

❑ Red Eye
❑ Blurry Vision (Distance/near)
❑ Glaucoma Suspect
❑ Dry Eye Testing
❑ Macular Degeneration
❑ Other:_____
❑ Failed Vision Screening
❑ Diabetic Eye Exam
❑ Headaches
❑ Plaquenil Testing

❑ **SPECIAL TESTING** (check the box for each test)
□ Referral of complete care of patient
□ Complete special testing only

❑ OCT Macula
❑ OCT Nerve
❑ Corneal Topography
❑ Visual Field (❑ 30-2, ❑ 24-2, ❑10-2)
OD: _____
OS: _____

❑ **EMERGENCY EYE CARE**
- Add other important details below

Was treatment initiated? □ **Yes** □ **No**
If Yes (medication name/dosing/eye):_____

Other Pertinent Medical/Family/Eye History: _____

To refer this patient, please fax or encrypted email copy of this form along with any relevant records. Wallerich Eye Care, will reach out to schedule your patient as soon as possible (no later than 48 hours). A report and/or copy of the exam findings will be sent back to your office if a fax number or HIPAA compliant email is provided.

Signature of Provider/Professional Referral Date