1075 Yorba Place, Suite 205
Placentia, California 92870

714.912.7002
714.975.9822 *fax*

www.tapadiaeyecare.com

Referral Request Form

Date of referral: ______________________

Patient Information

Patient name: ______________________

Patient phone number: ______________________ Date of birth: ______________________

Patient address: ______________________

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Patient's primary language: ______________________ Interpreter needed? (Y/N): ______________________

Reason for referral

Date of examination: ______________________

Urgency of referral: ☐ Urgent (within 1 day) ☐ Semi-urgent (within 1 week) ☐ Routine

Note: Please call us for urgent referrals.

Diagnosis/reason for referral: ______________________

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Insurance Information

Self pay? (Y/N): ______________________

Primary insurance name and type (PPO, POS, etc): ______________________

Note: For CalOptima referrals, please use CPT 99205.

Referring Clinician's Information

Referring clinician's name: ______________________

Referring clinician's NPI: ______________________

Name of practice: ______________________

Practice phone number: ______________________ Practice fax number: ______________________

Please fax this form to 714.975.9822.
Please include all relevant exam notes, any relevant lab/testing results, and facesheet/demographics sheet.