Complete and print.

Reset Form

MAYO CLINIC

Patient Referral

Ophthalmology

Form content retained in medical record.
Route to HIMS Scanning.

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*	
Birth Date *(mm-dd-yyyy)*	Room Number (if applicable)
Mayo Clinic Number	

TO BE SCANNED

Instructions: Complete and fax to 507-538-7355.
Include pertinent clinical notes, ophthalmology imaging, visual fields, lab results, and neuroimaging (CT/MRI).

Patient Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*	Patient Phone

Referring Provider Name *(First, Middle, Last)*	Phone	Fax

Referring Provider Address *(Street, City, State, ZIP Code)*

Diagnosis

Reason for Referral — Provide referral details:

- Emergent? ☐ Yes ☐ No
- Surgery needed? ☐ Yes ☐ No
- Second opinion? ☐ Yes ☐ No

Subspecialty Requested

Primary

☐ Adult strabismus ☐ Cataract ☐ Cornea ☐ General optometric eye exam ☐ Glaucoma ☐ Low vision
☐ Neuro ophthalmology ☐ Oculoplastics ☐ Ocular oncology ☐ Pediatrics ☐ Retina ☐ Scleral lenses ☐ Uveitis

Secondary

☐ Adult strabismus ☐ Cataract ☐ Cornea ☐ General optometric eye exam ☐ Glaucoma ☐ Low vision
☐ Neuro ophthalmology ☐ Oculoplastics ☐ Ocular oncology ☐ Pediatrics ☐ Retina ☐ Scleral lenses ☐ Uveitis

Date of Last Visit With Referring Provider *(mm-dd-yyyy)*

Additional Pertinent Medical Information

Print