CLEAR VISION CLINIC: PATIENT REFERRAL FORM

Referring to Dr. Sarah Covey, MD

1651 E Stearns St, Ste 110, Fayetteville, AR 72703

Fax 479-579-2067 | Call/Text 479-425-3541

REFERRING DOCTOR INFORMATION

Referring Doctor

Date of Request

Practice Name

Clinic Phone

Clinic Fax (for consultation report)

PATIENT INFORMATION

Patient's Name

Patient's DOB

Patient's Primary Phone

Primary Insurance

Please note: Clear Vision Clinic does not participate with Medicaid and does not accept strabismus referrals.

REASON FOR REFERRAL

- ☐ Cataract Evaluation
- ☐ YAG Capsulotomy Evaluation
- ☐ Glaucoma / Ocular Hypertension
- ☐ SLT Evaluation
- ☐ Laser Iridotomy Evaluation
- ☐ Other:
- ☐ Diabetic Eye Disease / Macular Edema
- ☐ Macular Degeneration
- ☐ Retinal Tear / Retinopexy
- ☐ PRP / Proliferative Diabetic Retinopathy
- ☐ Abnormal Optic Nerve / Needs Ultrasound

Cataract evaluation: Please include recent vision and refraction to help expedite pre-op.
Advise artificial tears QID and no contact lens wear for 2 weeks before pre-op.

PERTINENT INFORMATION (if clinic notes/records are not being sent)

2 EASY WAYS TO REFER

1. SEND THIS FORM ONLINE

Complete the form online and click to send the referral instantly.
It will be sent securely to Clear Vision Clinic.

2. FAX YOUR CLINIC NOTE

Fax the clinic note and patient demographics to 479-579-2067.

SCHEDULING

All referrals are scheduled at the first available appointment.

Urgent referral? Call or text 479-425-3541 and we will accommodate the patient as needed.

"Your patient stays your patient."

Cataract patients return to their referring optometrist for postoperative and ongoing primary eye care whenever appropriate.