



# RETINA CONSULTANTS OF SOUTHERN COLORADO, P.C.

Practice dedicated to medical and surgical diseases of the retina and vitreous

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## Fax Referral Form

★ Please include exam notes and demographics with referral ★

Pages attached: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone# Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Reason for consultation/diagnosis: \_\_\_\_\_

\_\_\_\_\_

How long have symptoms been occurring? \_\_\_\_\_

Schedule appointment:  Today  Within 2-3 days  Within 1 week  Next Available

Referring Physician: \_\_\_\_\_

Location: \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Physician Fax: \_\_\_\_\_

Tri-Care Prime Patient? Authorization **MUST** be requested by Referring Doctor:  Completed

**Fax To:**  Colorado Springs office  
2770 North Union Blvd., Suite 140  
Colorado Springs, CO 80909  
Fax: (719) 227-0669  
Phone: (719) 473-9595

Pueblo office  
3691 Parker Blvd. Suite 101  
Pueblo, CO 81008  
Fax: (719) 583-1582  
Phone: (719) 583-1575

**Thank you for the referral!**

RCSC OFFICE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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