



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

Pueblo office
3691 Parker Blvd. Suite 101
Pueblo, CO 81008

Phone: (719) 473-9595 Fax: (719) 227-0669

Thank you for the referral!

RCSC OFFICE: _____

Initials: _____ Date: _____

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