HealthCare

REFERRAL FORM

OPHTHALMIC GENETICS CLINIC

Dear Provider,

Thank you for referring your patient to Ramiro Maldonado, MD, Director of Ophthalmic Genetics. In order to better assist with your referral, please complete the following questions:

Patient: _____

Patient phone: _____

Patient DOB: _____

Reason for referral/ suspected diagnosis: _____

Referring provider name: _____

Referring provider phone number: _____

Date of referral: _____

I am referring this patient for:

- ☐ **Full consultation** (this will include MD evaluation, electrophysiologic testing determined after evaluation, genetic testing and genetic counselling when appropriate)
- ☐ **Electrophysiology** testing only - no MD evaluation.
  - Please don't select this option if you are suspecting an inherited retinal disease).
  - If you don't select a test or tests, we will make that recommendation based on the suspected diagnosis and records you send.

Please select the desired test:

- O Full-field ERG (ff-ERG)
- O Multifocal ERG (mf-ERG)
- O Visual evoked potentials (VEP)
- O Electro-oculogram (EOG)
- O Dark adaptometry
- O Microperimetry

If you have any questions, call **859-323-5867**. Please return this form by fax with current patient notes, with ATTN: Diane, to **859-257-6718**.