

**REFERRAL FORM**

**DIRECTIONS:** Please fax: Newburgh 845-562-1162 Middletown 845-692-7214

Or

Give to the patient to bring to the appointment

Referring Doctor: \_\_\_\_\_

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

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Telephone Contact Number \_\_\_\_\_

Date of Appointment \_\_\_\_\_

Office:  Newburgh  Middletown

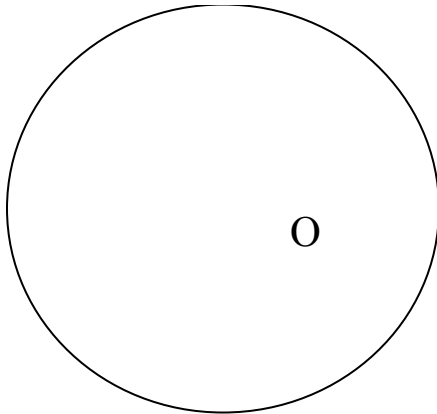
Dr. Green  Dr. Koreen

**Reason for Consult:** OD OS OU

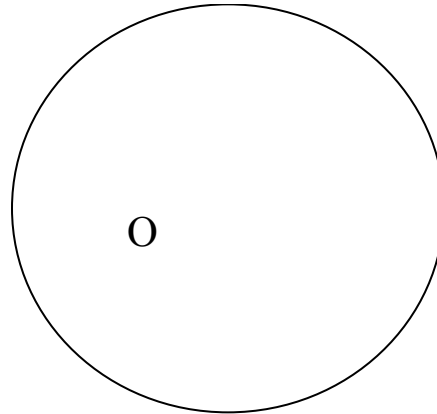
- Diabetic Retinopathy
- Macular Degeneration
- Macular Edema
- Flashes and Floaters
- Retinal Tear
- Retinal Detachment
- Other: Please specify \_\_\_\_\_

- Central Retinal Vein Occlusion
- Branch Retinal Vein Occlusion
- Maculopathy
- Choroidal Nevus/ Melanoma/Mass
- Uveitis
- Unexplained Visual Loss

OD



OS



Comments: \_\_\_\_\_

450 Gidney Avenue  
Newburgh, New York 12550  
845-562-1100

75 Crystal Run Road  
Middletown, New York 10941  
845-692-7200