N. Marie Koederitz, MD

Pediatric Ophthalmology & Adult Strabismus

ADULT STRABISMUS REFERRAL FORM

Please fax this form along with previous eye exam records, clinic notes, test results, prior surgical reports.

Patient Information

Patient Name: _____

Date of Birth: _____ / _____ / _____

Phone: _____

Email: _____

Insurance: _____

ID Number: _____

Referring Provider Information:

Date Referred: _____ / _____ / _____

Date Exam: _____ / _____/ _____

Referring Provider: _____

Practice Name: _____

Phone: _____

Fax: _____

Adult Strabismus Referral (Check all that apply)

- ☐ Esotropia
- ☐ Exotropia
- ☐ Vertical Deviation
- ☐ Nerve Palsy _____
- ☐ Diplopia
- ☐ Nystagmus
- ☐ Other: _____

Prior Treatment/Tests (describe below)

- ☐ Prism Glasses
- ☐ Imaging
- ☐ Labwork
- ☐ Prior strabismus surgery

Additional Notes or Comments:

_____

_____

_____

Thank you for your referral! After Dr. Koederitz reviews the information, we will contact the patient to schedule an appointment.

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