N. Marie Koederitz, MD
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Pediatric Ophthalmology & Adult Strabismus

Please fax this form along with any relevant clinical notes, vision screening results, and previous eye exam records if available.

Patient Information

Patient Name: ____________________________

Date of Birth: ____ / ____ / ______

Parent/Guardian Name: ____

Phone: __________________________________

Secondary Phone: ________________________

Insurance: _______________________________

ID Number: _______________________________

Reason for Referral (Check all that apply)

- ☐ Amblyopia (Lazy Eye)
- ☐ Strabismus (Eye Misalignment)
- ☐ Refractive Error (Glasses Needed)
- ☐ Failed Vision Screening
- ☐ Eye Infection or Inflammation
- ☐ Tearing or Blocked Tear Duct
- ☐ Ptosis (Droopy Eyelid)
- ☐ Nystagmus (Involuntary Eye Movements)
- ☐ Congenital or Genetic Eye Conditions
- ☐ Other: _____________________________

Referring Provider Information:

Date: ____ / ____ / ______

Referring Provider: _________________________

Practice Name: ____________________________

Phone: ____________________________________

Fax: _______________________________________

Preferred Urgency

- ☐ Routine (Next Available)
- ☐ Urgent (Within 1-2 Weeks)
- ☐ Emergency (Same Day – Call First)

Additional Notes or Concerns:
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Thank you for your referral! We will contact the patient’s family to schedule an appointment.

Fax to: 785-260-6275

Phone: 785-856-7732

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