N. Marie Koederitz, MD
Chelsea Scriven, OD

PEDIATRIC REFERRAL FORM

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:

_____

Cell Phone: _____

email: _____

Insurance: _____

ID Number: _____

Reason for Referral (Check all that apply)

- ☐ Routine Exam (Dr. Scriven)
- ☐ Failed Vision Screening
- ☐ Amblyopia (poor vision one/both eyes)
- ☐ Strabismus (Eye Misalignment)
- ☐ Eye Infection or Inflammation
- ☐ Tearing or Blocked Tear Duct
- ☐ Ptosis (Droopy Eyelid)
- ☐ Nystagmus (Involuntary Eye Movements)
- ☐ Congenital or Genetic Eye Conditions
- ☐ Absent Red Reflex (emergency, call)
- ☐ Other: _____

Referring Provider Information:

Date: ____ / ____ / _____

Referring Provider: _____

Practice Name: _____

Phone: _____

Fax: _____

Preferred SPECS Provider

- ☐ Dr. Koederitz
- ☐ Dr. Scriven
- ☐ First Available

Preferred Urgency

- ☐ Routine (Next Available)
- ☐ Urgent (Within 1-2 Weeks)
- ☐ Emergency such as absent red reflex please Call office first to schedule and fax notes.

Additional Notes or Concerns:

_____
_____
_____

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

346 Maine St, Suite 400, Lawrence, KS 66044
2835 Mission Woods Dr, Suite F, Topeka, KS 66614
Ph: 785-856-7732 F: 785-260-6275
www.sunflowerpediatriceyecare.com