LONG
BEACH
RETINA

Roberto Roizenblatt MD

Fax to : 562.363.0685

Patient name ______________________ DOB ____________

Phone number ______________________ Insurance ____________

Reason for referral (write or check a box)

- ☐ Diabetic retinopathy or screening
- ☐ Wet AMD
- ☐ Dry AMD
- ☐ Flashes/floaters
- ☐ Macular edema
- ☐ Retinal lesion
- ☐ Vein Occlusion
- ☐ IOL evaluation
- ☐ Retinal detachment
- ☐ Retinal tear
- ☐ Epiretinal membrane
- ☐ Macular hole
- ☐ Uveitis

To be scheduled:

- ☐ Immediately (call us directly)
- ☐ Within 1 week
- ☐ Within 1 month
- ☐ Patient preference

Diagnostic testing only:

- ☐ OCT macula
- ☐ B-scan

Referring Doctor ______________________ Office phone ____________

Internal use: called pt ☐ scheduled pt ☐

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