Legacy Devers Eye Institute
Retina Service - New Patient Referral Sheet

Please complete this form AND fax relevant chart notes to:

503-225-8779

Doctor: ☐ Sirichai Pasadhika, MD ☐ Aristomenis Thanos, MD ☐ First avail.

Referring Doctor:

Name: ______________________________ O OD O MD O DO

Phone#: _____- _____ - ______ **FAX#:** _____- _____ - ______ **Date of Referral :** _____/______/__________

Patient Information:

Name: ______________________________

Phone#: (_____)-_____- ________ **Date of Birth:** ___-___-_____ **Birth Sex:** O M O F

☐ Please FAX face sheet with basic demographics and insurance information

☐ Patient needs financial assistance

Referring Pathology: ☐ Right Eye ☐ Left Eye ☐ Both Eyes

☐ Retinal tear/hole

☐ **Retinal Detachment (please call)**

☐ Macular degeneration O Dry O Wet

☐ Diabetic Retinopathy O DME O PDR

☐ Dislocated Intraocular Lens

☐ Retinal Vein Occlusion O BRVO O CRVO

☐ Retinal Artery Occlusion

☐ Vitreous hemorrhage

☐ Epiretinal membrane

☐ Macular hole

☐ Uveitis

☐ Retinal/Choroidal mass/tumor

☐ Other: ______________________________

For emergent same-day referrals please call: 503 - 413 - 8080

Scheduling Urgency:

☐ **Immediately** (please call)

☐ Within 48 hours

☐ Within 1-2 weeks

☐ When patient prefers/ next available

☐ Other: ______________________________

Preferred Location:

☐ **NW Portland -** 1040 NW 22nd Ave, Portland, OR 97210

☐ **Tualatin -** 7021 S.W. Nyberg St., Tualatin, OR, 97062-6248

☐ **Vancouver -** 2501 NE 134th St., Ste 101, Vancouver, WA, 98686

Upon receipt, we will contact your patient within one business day to schedule the requested appointment. We will also contact your office to inform you of the upcoming appointment date/time.