TEXAS RETINA INSTITUTE

Valla Djafari, MD
Aaron Brock Roller, MD

PATIENT REFERRAL FORM

Please Include Last Exam Note with Referral

Patient: _____

Date of Birth: _____ Patient Phone: _____

Appointment Date: _____ Time: _____

☐ Austin

3807 Spicewood Springs Rd.
Suite 101
Austin, TX 78759

☐ South Austin

2610 South IH 35
Austin, TX 78704

☐ Round Rock

4010 Sandy Brook Drive
Suite 105
Round Rock, TX 78665

Referring Doctor: _____ Doctor Phone: _____

☐ OD ☐ OS ☐ OU

Reason for Consultation:

- ☐ Diabetic Retinopathy
- ☐ Macular Degeneration
- ☐ Macular Hole
- ☐ Retinal Tear/Detachment
- ☐ Epiretinal Membrane
- ☐ Retinal Vascular Occlusion
- ☐ Posterior Vitreous Detachment / Flashes / Floaters
- ☐ Choroidal Nevus or Other Lesion
- ☐ Other _____

Referral Instructions:

- ☐ Consultation: Exam and Treatment
- ☐ Second Opinion
- ☐ Imaging only (no interpretation):
  - ☐ OCT Macular Scan
  - ☐ OCT Optic Nerve Scan
  - ☐ B-Scan / ultrasound
  - ☐ Fluorescein Angiography
- ☐ Other: _____

Please note - all requests for imaging **with interpretation require a full consultation**