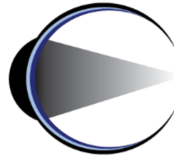


NORTHERN CALIFORNIA
RETINA VITREOUS ASSOCIATES
ESTABLISHED IN 1983

Patient Referral Form – Please Fax to Preferred Location

Physicians

Mark R. Wieland, M.D.
James D. Palmer, M.D.
J. Luigi Borrillo, M.D.
Rahul Khurana, M.D.
Alok S. Bansal, M.D.
Louis K. Chang, M.D. Ph.D.
Jay Wang, M.D.

Locations

Mountain View
2495 Hospital Drive
Suite 545
Mountain View, CA 94040
(P): 650-963-3460
(F): 650-963-3480

San Mateo
50 S. San Mateo Drive
Suite 125
San Mateo, CA 94401
(P): 650-340-0111
(F): 650-340-9689

West SJ - Good Samaritan
2512 Samaritan Court
Suite P
San Jose, CA 95124
(P) 408-356-8818
(F) 408-356-8849

East SJ - San Jose
200 Jose Figueres Ave
Suite 415
San Jose, CA 95116
(P) 408-251-3500
(F) 408-251-3535

Monterey
798 Cass Street
Suite 200
Monterey, CA 93940
(P) 831-373-6280
(F) 831-373-0151

Daly City
901 Campus Drive
Suite 215
Daly City, CA 94015
(P) 650-994-2100
(F) 650-994-2121

Doctor Requesting Consult: ______________________ Office Phone: ______________________________

Patient Name: _______________________________ Patient Phone: _______________________________
(Home/Cell) (Work)

Patient Primary Insurance: ____

☐ Medicare Advantage ☐ HMO ☐ PPO ☐ Other

Secondary Insurance: ____

Referring To NCRVA Dr: ☐ First Available ☐ Specific Doctor: _________________________________

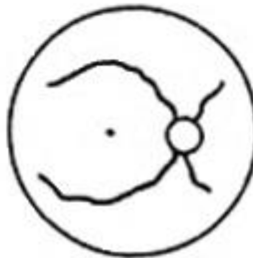
To be scheduled: ☐ Immediately (Please Call Office) ☐ Within 1 week ☐ Within 1 month ☐ Patient preference

Requesting Office: Please fax this form to the preferred NCRVA location. If emergency/urgent, please call NCRVA location.

Visual Acuity: R.E. 20/_____________ L.E. 20/_____________

Fundus Areas of Interest

OD



OS

Consultation for: ____ *(or check a box below)*

☐ Wet AMD or CNV (L/R) ___
☐ Dry AMD (L/R) ___
☐ Epiretinal Membrane (L/R) ___
☐ Diabetic Retinopathy (L/R) ___
☐ Macular Edema (L/R) ___
☐ Other Macular Edema (L/R) ___
☐ PVD/Flashes/Floaters (L/R) ___
☐ Retinal Tear (L/R) ___
☐ Retinal Detachment (L/R) ___
☐ Retinal Lesion (L/R) ___
☐ Retinal Vein Occlusion (L/R) ___
☐ Uveitis (L/R) ___

Diagnostic Testing Only:

☐ OCT Macula ☐ OCT – RNFL ☐ B-Scan

Patient: **When scheduling the appointment, please let us know if you will need a translator during your appointment. Please bring this form with you to your appointment and complete your new patient packet on our website, www.ncrva.com, before your appointment. You can also find driving directions, maps, information about your doctor and about our current research studies on www.ncrva.com. We look forward to seeing you!**

FOR INTERNAL USE:

Referral Received via: ☐ **Fax** ☐ **Phone on:** ____________________ **Staff Name:** ______________________

____________ Date **referral** and **appt confirmed** with referring office

____________ Date **notes** requested from referring office

____________ Date **notes** requested from previous retina specialist ☐ N/A

____________ Date **notes** requested from PCP/Endocrinologist ☐ N/A

Comments:
____
____
____