SOUTHEASTERN OCULARISTS, INC.
Custom Made Ocular Prosthetics

Patient Referral Form

Name: _____ DOB: _____ Gender: **F / M**

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____

Preferred contact (if not patient): _____

Insurance 1: _____ ID# _____

Insurance 2: _____ ID# _____

Veteran? Y / N

Referred By:

Physicians Name: _____ Physicians NPI: _____

Office Name: _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Referral Date: _____ Affected Eye: RT / LT

Reason for Referral: _____

_____

Please include most recent visit note with this referral form.

Send by fax or email to:

F: 704-510-9881 E: admin@seocularist.com

CHARLOTTE LOCATION
8426 Medical Plaza Drive # 500
Charlotte, NC 28262
704.510.9292

MT. PLEASANT LOCATION
1300 Hospital Drive #260
Mt. Pleasant, SC 29464
843.884.7113

704.510.9881 | www.seocularists.com

Rx

Henderlite B.C.O., Robert L.
Southeastern Ocularists, Inc
8426 Medical Plaza Dr # 500, Charlotte, NC 28262
Phone# 704.510.9292
Fax# 704.510.9881

Patient:

DOB: Gender:
Address:
Phone:

Diagnosis: Q11.1 (Other Anophthalmos)

Procedure: Please fit with a new Custom Ocular Prosthesis, Conformer, or Scleral Shell.

By signing this, I certify that I have examined the patient and have determined that this procedure is medically necessary.

Physicians Name: _____ Physicians NPI: _____

Physicians Signature: _____ Date: _____

Rx

Henderlite B.C.O., Robert L.
Southeastern Ocularists, Inc
8426 Medical Plaza Dr # 500, Charlotte, NC 28262
Phone# 704.510.9292
Fax# 704.510.9881

Patient:

DOB: Gender:
Address:
Phone:

Diagnosis: Q11.1 (Other Anophthalmos)

Procedure: Please adjust their Custom Ocular Prosthesis, Conformer, or Scleral Shell.

By signing this, I certify that I have examined the patient and have determined that this procedure is medically necessary.

Physicians Name: _____ Physicians NPI: _____

Physicians Signature: _____ Date: _____

Rx

Henderlite B.C.O., Robert L.
Southeastern Ocularists, Inc
8426 Medical Plaza Dr # 500, Charlotte, NC 28262
Phone# 704.510.9292
Fax# 704.510.9881

Patient:

DOB: Gender:
Address:
Phone:

Diagnosis: Q11.1 (Other Anophthalmos)

Procedure: Please polish their Custom Ocular Prosthesis, Conformer, or Scleral Shell.

By signing this, I certify that I have examined the patient and have determined that this procedure is medically necessary.

Physicians Name: _____ Physicians NPI: _____

Physicians Signature: _____ Date: _____