

*North Valley Eye Care*

**1700 Bruce Rd.  
Chico, California 95928**

**Phone: (530) 891-1900  
Fax: (530) 895-1531**

**Prior Referral Request Form**

To PCP/Facility: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ Fax#: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Anticipated Appt. Date: \_\_\_\_\_ with Dr. \_\_\_\_\_

The above patient carries an insurance that may need a prior referral or authorization as they may be enrolled in a managed care plan. The necessary referral or authorization is needed before our ophthalmologist is able to see them for this visit.

Along with a complete annual eye exam and refractive error checks, our ophthalmology services may also include various eye testing and examination services when patient may show such indications of:

- |                            |                        |                                  |
|----------------------------|------------------------|----------------------------------|
| Diabetic Retinopathy       | Strabismus             | Pterygium                        |
| Retinopathy of Prematurity | Dermatochalasis        | Herpetic Eye Infection           |
| Cataracts                  | Eye Pain               | Retinal Detachment               |
| Glaucoma                   | Corneal Scar or Ulcer  | Age Related Macular Degeneration |
| Amblyopia                  | Foreign Body in Cornea |                                  |
| Nystagmus                  | Dry Eye Syndrome       |                                  |

**Examples of possible additional testing may include:**

- Dilated Fundus Exam
- External Photography
- Topography
- Fundus Photography
- Ocular coherence Tomography (OCT)
- Ultrasonography A-Scan/ B-Scan
- Visual Field Examination
- Sensorimotor Exam

\_\_\_\_\_  
Referring Physician Signature

\_\_\_\_\_  
Referring Physician NPI #

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